IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

CARISSA PERONIS, et al.,
Plaintiffs
vs.
UNITED STATES OF AMERICA, et al.,
Defendants.

Civil Action No. 16-1389

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Transcript from proceedings on August 28, 2019, United States District Court, Pittsburgh, PA, before Judge Nora Barry Fischer.

APPEARANCES:

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Proceedings recorded by mechanical stenography; transcript produced by computer-aided transcription.

THE COURT: Morning, everyone. You'll recall at the end of yesterday's proceedings, Mr. Galovich was talking to the jurors and the jurors expressed some confusion about note taking and the like. I think we've just been joined by -- I'm not sure whom.

MR. PRICE: That's Carissa's grandfather.

THE COURT: Potential witness?

MR. PRICE: No. Just a driver.

THE COURT: And?

MR. PRICE: Dr. Shore.

THE COURT: I think Dr. Shore need not be here. Thank you, Mr. Galovich. Some of the jurors expressed some confusion about the court's instructions vis-a-vis note taking, and as I indicated yesterday, I would be prepared to reinstruct the jurors as to what they may do or not do vis-a-vis note taking by reiterating what was previously said.

I've also been thinking about their other comments to Mr. Galovich, i.e., a number of them have questions, so apparently either they have questions about what you said in opening or they have questions about what some of the witnesses had to say.

Now, I'm aware there's another trial going on here in court, and Judge Ranjan is permitting the jurors to ask questions at the conclusion of each witness's testimony, and the way he is doing that is he gave them an instruction, and

at the conclusion of each witness' testimony, he is permitting them to write in his chambers on a Post-It note and put down a question.

The question is then submitted to the court and he makes a determination what, if any, of the questions are read, instructing the jurors that to the extent he does not use a question, it's because of the fact that their question may be eliciting information that's already been ruled or deemed inadmissible for the case.

So the court is wondering, given the jurors', in my words, persistence in talking to Mr. Galovich, whether we should or should not be employing such a procedure.

So one thought I had overnight was that when Mr. Galovich goes back once they are all there and I think they are just about all there, that he, number one, inquire of them, do their questions relate to witness testimony or do they relate to their duties as jurors, and perhaps get them before they come back out here to write down on a piece of paper without reference to their name or juror number what these questions are and then we can deal with these questions.

So I'm looking to counsel to see if they have any comment about this. Now, interestingly, we recently had a case go to verdict in a different chambers, and there, the jurors had a number of questions as well and some of those questions went to, for example, were there attempts to settle

the case.

Well, obviously the court can't comment on such a question, so who knows what's on their minds?

Mr. Price, what's your view vis-a-vis having these jurors submit questions?

MR. PRICE: Never been asked, but why not? We do it after they deliberate. If they want to ask questions, they can ask questions by paper. It would be, I guess, interesting to find out what they are thinking now, so I don't have really a problem with it.

THE COURT: Mr. Colville? The jury really is not within your purview, let's put it that way.

MR. COLVILLE: I'm not sure what to say, Your Honor. They are not -- they shouldn't be, yet we're trying the case.

THE COURT: You are trying the case to me, too. I'm the ultimate fact-finder vis-a-vis the U.S. I understand that.

MR. COLVILLE: The questions that are asked, I don't know. What if they asked questions that only Dr. Zamore might be able to answer. That time has come and gone for me to clean up or follow up with questions.

THE COURT: Understood.

MR. COLVILLE: But I don't understand yet what the confusion is, so it may very well be it's a nonissue.

THE COURT: It may well be.

Ms. Koczan?

MS. KOCZAN: Your Honor, I would like to know what the confusion is first before I offer any comment. I've never done this before. I'm not adverse to it, but again, I don't know what the questions are, and it is somewhat concerning because there have been witnesses on and off that we couldn't answer questions about.

THE COURT: Right. Well, I've been trying cases here for the last 12 and a half years. This court has not been confronted with this issue. There are pros and cons to having jurors asking questions. I've read the literature on same. I've not employed it to this point in time, but this early in the proceedings, given the fact that these folks seem to have some queries and that they feel comfortable enough, if you will, to press them on Mr. Galovich, I thought that, number one, we should bring it to your attention; and number two, consider what we might want to do with that.

So I think what I'm going to do is have Mr. Galovich go back since all the jurors are back there, number one, and I'm going to ask him to ask the jurors generally, outside of their concern or issue relative to note taking, what is the nature of their questions.

If they relate to the proceedings, I'm going to ask Mr. Galovich to have them write them down on a piece of paper without indication of which juror or juror number is involved.

Then he'll bring those out and then we'll address whether we do or don't answer those questions at this stage and how we might proceed further.

The other thing that I would call to your attention is this: Yesterday, there were some folks in the galley as well as at counsel table who were reacting to testimony. That's totally inappropriate in this courtroom. There was particularly a woman with a flowery sweater on who demonstratively reacted several times through the proceedings. She was in and out of the courtroom. That's not only a distraction, but it's totally inappropriate in this chambers or in this courtroom or anywhere else.

And I would also caution the parties and any other witnesses that, you know, this is a sober affair, one.

Two, it's not appropriate to react to testimony in any way, shape or form. Everybody understand that?

Whoever that woman was, she was a brunette with a sweater who was in and out of here yesterday and seated behind Ms. Wolf most of the time. If she appears here today, Mr. Galovich is going to take her aside and we're going to admonish her.

MS. KOCZAN: I'm not sure who that is.

THE COURT: Neither am I, because these people do come and go, but she seemed to have some affiliation to the defense team, you know. Whether she is a paralegal, a

secretary, another attorney or a hospital employee, it's hard for me to divine.

Mr. Galovich, if you'll go back and talk to our jurors at this time.

Mr. Price, we know Dr. Shore is here. Have you and Ms. Koczan worked out the schedule for the rest of the day?

MR. PRICE: Yes, Your Honor. Dr. Shore will be first to testify. Nurse McCrory will be next. We have a witness Tyler Janectic, who, because of work obligations, will have to testify before lunch so he's on his way and he will probably be testifying probably after the break. His testimony should not be more than 10 or 15 minutes. He's a factual witness. After that, I'll call Dr. Bradley Heiple who is the resident doctor.

Following that, I will be calling Matthew in the afternoon, depending upon how far we go with Dr. Heiple and with Nurse McCrory, so my plan is to call Matthew Fritzius, and then I have arranged for Dr. Kenkel, who was scheduled for tomorrow, I moved him up to today since we are moving faster so we can get the day filled, so he's going to be here at 3:00 and he should take us to the end of the day.

THE COURT: Thank you. Anything else for the court's attention? I see Ms. Loftus has just arrived.

MR. PRICE: Your Honor, one of the other issues -- the only other issue I mentioned was that I do have the five

original photographs which are already in the joint exhibits. How does the court want me to handle introducing the actual originals? I plan to simply supplement the record and say that I have the originals which I would like to, at the end of my case, publish to the jury so --

THE COURT: Mr. Price, finish what you were going to say despite what Mr. Galovich is doing.

MR. PRICE: I would publish that to the jury following the close of my case so they could actually see them, and they would be, I guess, attached to the joint exhibit trial binder for -- but I only have one copy of the original photograph.

THE COURT: Understood. Okay. Any objection to those "original" photographs going back to the jury?

MS. KOCZAN: Your Honor, may I see them?

THE COURT: Yes.

Mr. Price, share those with Ms. Koczan as well as Mr. Colville.

MS. KOCZAN: I'm fine.

THE COURT: She has no objection. Mr. Colville?

MR. COLVILLE: No objection.

THE COURT: So, as you indicated, Mr. Price, number one, I think you can simply move them into admission. There's no objection, one.

Number two, they can be passed to the jurors and then

gathered up, and then in addition, each of these jurors when they go out will have the binders, and in addition, they'll have any singleton exhibits that have been admitted.

So if you want those pictures to go back to the jury room, they can go back to the jury room as far as I'm concerned.

MR. PRICE: Finally, have the Gatorade bottles been taken? We are no longer using them.

MR. COLVILLE: We have pictures.

THE COURT: And the picture was provided to Mr. Galovich, correct?

MR. COLVILLE: Correct.

THE COURT: Mr. Galovich, you came in and you were signaling something to me.

THE CLERK: I gave them five minutes. I said would run back in a few minutes.

THE COURT: Thank you.

THE CLERK: I told them not to discuss their questions with one another in that respect.

MR. COLVILLE: Your Honor, while we have this time, looking forward scheduling-wise, Doug, what do we think witness-wise?

MR. PRICE: Tomorrow morning, I have Dr. Karotkin. After that, I have Kylee Fritzius, she is a factual witness, would not take that long. Then I'm going to be calling

Carissa and I will be done. I might be done by noon.

MR. COLVILLE: What about Dr. Min?

MR. PRICE: I'm sorry, Dr. Min will be tomorrow morning, too. I don't expect him to be very long. I mean, of course, defense might have a lot of questions, but then I would be done by midafternoon tomorrow.

THE COURT: Okay. Thank you. Then we might have a Rule 50 motion and argument?

MS. KOCZAN: Correct.

THE COURT: The court will be prepared to rule.

MS. KOCZAN: Your Honor, do you want my motion today then?

THE COURT: Well, I would like your motion and brief if you have one.

MS. KOCZAN: I do.

THE COURT: The sooner I get it, the better. Was it filed on the docket?

MS. KOCZAN: Not yet. I'll have someone bring it up today.

THE COURT: Okay.

MS. KOCZAN: Then, Your Honor, in terms of my witnesses, as I indicated at the start of the trial, I have all of my witnesses because of what we believed to be no court on Friday earlier, I have all of my experts scheduled for the 4th, which would be that Wednesday. I have Nurse Hackney,

Nurse Ash that we can put on on Tuesday or Friday, whichever you prefer, and then my other experts, I'm going to try to have them all here on that Wednesday so we can just go in order.

I'm trying to see if I can get one of them on the 3rd, but they had all arranged for the 4th or 5th thinking that we were not going to be in session on Friday.

THE CLERK: Your Honor, they said they have no questions.

THE COURT: Okay. Well, then that's good.

MR. COLVILLE: From the government's end, Your Honor, we'll have Dr. Wiesenfeld here first thing Tuesday morning. That will be our only witness.

(Jury present.)

THE COURT: Good morning, ladies and gentlemen of the jury. I trust that you had smooth travels coming in today, once again, despite the rain.

At the end of yesterday's proceedings, Mr. Galovich advised me that some or all of you wanted the court to revisit with you my instructions vis-a-vis note taking, and as you'll recall, I told all of you note taking is certainly permitted but it's not required, and you can either take your notes on the little pads that you have or you can take them actually on those exhibits, because those exhibits are for your use, and as you heard, all of the paper, all of the exhibits that are

contained in those binders is now a part of the trial. They are all admitted into evidence, and you've seen certain of these documents actually blown up and put up on the screen, but everything there that's before you is also for your consideration.

So in any event, each of you can take notes, but no one is required to take notes. I also instructed you to be brief. Don't try to summarize all of the testimony. Notes are for the purpose of refreshing memory. You may have noted, just like you, I take notes, and sometimes witnesses talk too fast, sometimes you don't capture everything, but you need to put down what you think will jolt your memory once you start deliberating.

They're particularly helpful when dealing with measurements, times, distances, identities and relationships, but overuse of note taking can be distracting, because you must determine the credibility of the witness, so it's up to you to observe the demeanor and appearance of each person on the witness stand. Note taking must not distract you from that task.

If you wish, to make a note, you need not sacrifice the opportunity to make important observations. You may make your note after you have made an observation. So in a nutshell, what that's saying is that it's up to you to take a look at the witness, watch the witness come up to the witness

stand, watch the witness when the witness is on the stand and make your determinations using your own background, experience and common sense, is this person credible or not.

Thirdly, don't use your notes or any other juror's notes as authority to persuade fellow jurors. This is going to come in more at the end of the trial because, in your deliberations, you should give no more or no less weight to the views of a fellow juror just because that juror did or didn't take notes.

As I mentioned earlier, your notes are not official transcripts. They are not evidence. They aren't a complete outline of the proceedings. At most, they are a list of highlights of the trial. They are valuable, if at all, only as a way to refresh your memory, as I indicated a minute ago.

Your memory is what you should be relying on when it comes time to deliberate and render your verdict in this case. You, therefore, are not to use your notes as authority to persuade fellow jurors of what the evidence was during the trial. Notes are not to be used in place of the evidence. "The evidence" meaning the testimony and meaning all those exhibits in your respective juror binders, and by the way, there may be some singleton exhibits that come in during the trial as well besides what's in those binders.

Last, but not least, I also instructed you that you can't take your notes away from the court, and maybe you might

be tempted to take that binder home at night and study it, but, no, you can't do that.

At the end of every break and each day, you leave your notes, as you know. Mr. Galovich gathers them up. He has a big -- looks like a shopping cart that he borrows from the clerk's office. He puts everything in that and he literally locks that in our exhibit closet overnight, and every morning when he comes in, he gets it all out. He wheels it to right outside this door and then he brings it in so that you have the benefit of those binders as well as your notes.

As I also told you, when the trial is all over, it's his job to take all of those notes back from you, and we literally destroy them, so whatever confidential notes that you put on the steno pad or in your exhibits, those are destroyed because, as I told you, your deliberations are secret.

So to that end, neither I, my law clerks, Mr. Galovich or anybody else is going to go through all of that to see what you were thinking as the case went through the trial, so we don't do that here at all. So I hope that that clarifies the instructions on note taking for anybody who had a pause or a concern about that, and I understand otherwise, you had an opportunity to think whether you had any other questions that you might want to pose, and at this point in time, I understand that you don't have any questions that

you might want to pose.

So I think we are ready to start, and to that end, Mr. Price has already alerted us to his next witness who will be Dr. Shore, and if you will bring in Dr. Shore, Mr. Price.

THE CLERK: Sir, will you please step forward? Please state and spell your name for the record.

THE WITNESS: Steven with a V, L. Shore, S-H-O-R-E, M.D.

(Witness sworn.)

THE COURT: Dr. Shore, watch your step getting up on the witness stand. It's a little uneven there. Once you are situated there, I have a short limiting instruction and Mr. Price may start. You may be seated. There's water there in case you need it.

As you were instructed yesterday, and let me remind you, you are now about to hear testimony containing opinions from Dr. Steven Shore. Dr. Shore is also a physician. He'll be offering opinions because of his knowledge, skill, experience, training or education in the field of pediatrics and pediatric infectious disease and the reasons for his opinions.

In weighing Dr. Shore's opinion testimony, you can consider his qualifications, the reason for his opinions and the reliability of the information supporting those opinions as well as the other factors that I will ultimately discuss in

my final instructions for weighing the testimony of witnesses.

The opinion of Dr. Shore should receive whatever weight and credit, if any, you think appropriate given all the other evidence in this case. You may disregard his opinions entirely if you decide they are not based on sufficient knowledge, skill, experience, training or education. You can also disregard his opinions if you conclude that the reasons given in support of the opinions are not sound, if you conclude that the opinions are not supported by the facts shown by the evidence or if you think that the opinions are outweighed by other evidence.

In deciding whether to accept or rely upon the opinions of Dr. Shore, you can also consider any bias that he may have, including any bias that may arise from evidence that Dr. Shore has been or will be paid for reviewing this case and testimony in this case. So with that limiting instruction, Mr. Price is ready to begin his examination.

MR. PRICE: Thank you, Your Honor.

STEVEN SHORE, M.D., a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PRICE:

Q. Dr. Shore, can you tell us what type of doctor, what type of medicine do you practice?

A. I'm trained both as a general pediatrician and I'm also

trained as a specialist in pediatric infectious diseases and immunology.

Q. Can you explain or tell us a little bit about pediatric infectious disease is and immunology is. What does that involve?

A. That involves generally looking at children and infants, teenagers with unusual infections, with unusually severe infections, and trying to find out how best to treat them as well as diagnose them. The major thing is to treat, but the diagnosis comes, that's well, but it's better to be able to help people.

The immunology part is to look and see if there's something wrong with certain kinds of children who suffer unusual infections or frequent infections, again to see if there's something we can do to reverse that trend.

Q. I know we can all hear you, but if you need to, you can adjust the microphone to make it more comfortable.

A. Okay.

Q. Now, I have to ask you about your qualifications so the jury understands your expertise and I'll go through it. You did -- you graduated from the University of Pennsylvania in 1963 and went on to medical school in 1967 and you graduated from Johns Hopkins?

A. Right. I went to Johns Hopkins in 1963, graduated in '67.

Q. Then you did an internship in pediatrics in 1966 through

'67 at Children's Hospital in Boston and a residency there for the next year?

A. Right. The reason there is that overlap is I accelerated when I went through Johns Hopkins. I did it in three years, and my senior year as a medical student, I was actually an intern at Boston Children's.

Q. And then you did a fellowship at Emory University in Atlanta?

A. That's correct.

Q. And then, I notice you worked for the government as a medical officer for the Center of Disease Control Biophysical Separation Unit and then the viral immunology branch of the virology division in charge of cellular immunology?

A. Right. That was from 1968 to 1981. HIV broke out in 1983, and had I known that was coming on, I suspect I couldn't have left CDC, but that was still two years away. It's just interesting how these things turn out in your life.

Q. You have faculty appointments where you have been a clinical assistant professor in pediatrics at Emory and your clinical associate professor in pediatrics at -- or clinical professor of pediatrics in Emory since 2001?

A. That's correct.

Q. And what's involved in that work?

A. Clinical staff means you are not paid for your work. You do it because it's the right thing to do. You see patients

along with people at different levels of training, and that could include anything from nurse practitioners, physician's assistants, fellows, residents, what have you, and there's also a lot of informal teaching that goes on in medicine, especially in infectious disease since we literally want to teach our colleagues in other disciplines how to take care of like infectious disease complications in surgery so the right thing is done so the complications are kept to a minimum.

Q. And you work with kids, you know, pediatrics and infectious diseases in kids, and you work with doctors, residents, fellows, nurse practitioners in treating, evaluating and trying to diagnose those conditions?

A. That's correct.

Q. And I know you are on staff at a few hospitals, North Side Atlanta in Atlanta, North Side Hospital in Atlanta, there's a Scottish Rite Children's Hospital. You also, since 1981, have been in private practice, and you are board certified in pediatrics and pediatrics infectious disease?

A. I was board certified in P&ID, infectious disease until Christmas of 2015, when they changed the rules and, quite frankly, being about 73 or 74, with the change in rules, I just did not sit for my recertification. I'm happy to take an exam, which was the way we used to do it and prove my credibility that way.

Q. So you were certified. You just let it lapse sort of?

A. Right. I took the first boards that were given in 1994 and then recertified by examination in 2001 and 2008, so I would have been board certified through December 2015.

Q. And in your work, whenever you were working for the government, I know there were a whole bunch of journals and book chapters that you published, and I'm not going to go through them all, but I noticed that a lot of them concentrated in pediatric infectious disease and the use of antibiotics.

A. Yes. A lot of them dealt -- a lot of my original research work was on herpes simplex virus which causes cold sores and also causes, by the way, neonatal sepsis. We actually published a couple articles recently on how to use certain kind of blood tests to diagnose that.

In addition, I co-authored a number of textbook chapters on invasive infections with different bacteria, especially when they lead to infections of bones and joints.

Q. Now, I guess the jury would like to understand your current practice. Do you treat kids every day or what do you do in medicine now as a doctor?

A. I'm a bit of a workaholic. I don't have off days. I have days where I work a little less. I see kids literally every day when I'm in town which is most of the time, and I'm -- half of my time, I'm in my pediatric office and the other halftime, I'm at the hospital seeing patients both at Scottish

Rite and at North Side Hospital.

Q. Are you called in to consult on patients such as Kendall Peronis in a case like this?

A. Yes.

Q. And do you teach doctors about cases where you come in about an infectious disease in a baby, a newborn?

A. Right. We try to decide if the antibiotics are right. We're not generally there when the event, such as happened in Kendall's case, but we then come in afterwards, and they want to know whether they are giving the right antibiotics, the right dose of antibiotics, whether the infection has settled somewhere else, the duration of therapy and what other diagnostic studies to do, so for example, the infection might not happen again or happen what we call a relapse.

Q. It's more of a neonatologist specialty or pediatrician that deals with the first resuscitation, that might be called to the delivery room. You deal more with we got an infection. How do we deal with it?

A. Right. In the old days, in the 1980s, we would resuscitate our own babies. We did everything. We attended C-Sections in the middle of the night and the like.

Things have gotten a little more organized in a place like North Side which has the largest NICU and nursery in the United States actually. So we have people from our NICU or a neonatologist attend deliveries. Now, not every hospital has

that kind of intensive NICU.

Q. Today, you are here testifying as a medical expert in the case, and as part of your work you do outside of medicine, you come in and you provide expert testimony?

A. I do.

Q. About how long have you been doing that?

A. Since approximately 1983, so about 35, 36 years.

Q. And how often do you look at a case such as this?

A. I get about three cases a month usually in the mail with a preceding phone call from a lawyer.

Q. And about how many times do you testify, like in a year?

A. By deposition, meaning, people take down my opinions at a deposition, it's about eight times, nine times a year in terms of deposition giving.

Q. How about times in court like this?

A. It averages at least, over the last 20 years, about twice a year.

Q. Have you ever testified for our firm before?

A. Not to my knowledge.

Q. And you still carry on an active practice, seeing patients and treating every day along with this work?

A. Sure.

MR. PRICE: That's all the questions I have, and I would offer Dr. Shore as an expert in pediatric infectious diseases and would offer for cross-examination.

THE COURT: Cross-examination, Mr. Colville?

CROSS-EXAMINATION EN VOIR DIRE

BY MR. COLVILLE:

Q. Good morning, Doctor. My name is Michael Colville. I work for the U.S. Attorney's Office and I represent the United States in this case.

A. Yes.

Q. Doctor, you are here as an expert in the area of pediatrics and pediatric infection; is that correct?

A. Correct.

Q. You are not here as an expert in the field of obstetrics; is that correct?

A. Correct.

Q. That's the specialty of Dr. Dumpe. Are you aware of that?

A. Yes.

Q. Is it safe to say that you do not manage the care, labor and delivery of newborns in your practice?

A. That's correct.

Q. You are not here to offer an opinion as to whether or not Dr. Dumpe met the standard of care as an obstetrical specialist; is that correct?

A. Right. I've not been asked to do that.

Q. From the materials that were provided to me from your counsel, you were just mentioning how much you testify as an expert or as a reviewer. You testify a lot. Is that an

accurate assessment?
A. I think that's fair, yes.
Q. From the document I received, it looks like, in the past four years, you've identified 46 cases where you have testified; is that right?
A. I think that's a Rule 99 I submitted, yes, sir.
Q. That testimony would be in depositions, arbitrations and trials, correct?
A. Correct.
Q. I assume you prep for these depositions, arbitrations and trials as well; is that right?
A. Sure.
Q. Does this interfere with your clinical practice at all?
A. No.
Q. It doesn't?
A. No.
Q. So you do this when?
A. When I'm off, at night, weekends and the like. Patients come first. This is obviously a secondary activity.
Q. What percentage of expert testimony is your income derived from?
A. I would say right now, a total of about 40 percent.
Q. So it's nearly half of your income is derived from testifying like you are today?
A. Yeah. It's getting closer every year.

Q. Now, the past four years, you've testified 46 times. We've established that.
A. Yes.
Q. That's an average of 11 per year; is that correct?
A. I guess -- well, it was four and a half years. I would say it's about ten per year, yes.
Q. Now, the testimony you are giving isn't in Atlanta where you live presently, right?
A. Right.
Q. Some is?
A. Some is in Atlanta.
Q. Most of it is not?
A. Most of it is not in Atlanta. Most of it is not in Georgia.
Q. 99 percent of it is elsewhere in the country; is that right?
A. Well, if you mean by Atlanta, I would say about 98 percent. I have two defense cases I'm now working on in Atlanta.
Q. The list you gave me of the 46 that you identified, 46 times you've testified in the past four years, 17 are in -- well, there's a handful that were in Georgia?
A. Right.
Q. The remainder were in other states across the country?
A. True.

Q. Have you ever lived in this community?
A. No, I've never lived in Pittsburgh. I'm from Philadelphia, but that's the other side of the state.
Q. Have you ever practiced medicine in this community?
A. No, I haven't.
Q. Is this the first time you have been to Pittsburgh?
A. No.
Q. When have you been to Pittsburgh previously?
A. I think I had a case here 20 or 25 years ago.
Q. Now, on the list, it looks like you've traveled, through the 46 times, to about 17 states; is that right?
A. I never codified it that way, but that sounds reasonable.
Q. Your list indicates you testified in Michigan, Maryland, Alabama, Missouri, North Carolina, Kansas, Florida, Tennessee, Georgia, Kentucky, Hawaii twice, Illinois a couple of times, South Carolina, Pennsylvania, Virginia, New Jersey, Louisiana.
A. Yes. Those were largely by deposition rather than trial, yes.
Q. Did I miss any states?
A. I wouldn't know. I can't keep track of them.
Q. But a lot of those states were duplicative. You've visited many states often?
A. I only go to trial twice a year. Some of the depositions are in my office, so I don't travel nearly that much.
Q. Of the 46 times that you've identified as testifying, only

six of them have you testified for the defense; is that correct?
A. In that list, that's correct.
Q. Well, this is the most current list you have, correct?
A. Right. It doesn't have the last year's testimony.
Q. But of the list you supplied us in this case, knowing that you were going to be testifying here today?
A. Yes.
Q. Of the 46 times you have testified, you've only testified for the defense on six occasions?
A. I'd say that's about right.
Q. So all the others have been for the plaintiff?
A. Correct.
Q. Does that affect your decision making process in any case?
A. No. I don't get to choose which cases are sent to me. Actually, the first five years I testified, they were all defense before a plaintiff's lawyer asked me if I would take any plaintiff's cases. Since that time, I've gotten mostly plaintiff cases in the mail.
Q. So you accept every case you receive?
A. I look at them, yes. I don't accept them. In terms of half the cases, I will probably find don't have merit.
Q. So it just happens in this case, of the 46, 40 of them you accepted they were for the plaintiff only?
A. I think six, yes.

MR. COLVILLE: Thank you.

THE COURT: Ms. Koczan, cross?

MS.KOCZAN: Yes, thank you.

CROSS-EXAMINATION EN VOIR DIRE

BY MS. KOCZAN:

Q. Just a few follow-up questions, Doctor. You told us you are a clinical professor of pediatrics, correct?

A. Yes.

Q. You are not on a tenure track?

A. No. I'm in private practice.

Q. And you are not currently board certified in pediatric infectious diseases, correct?

A. That's true.

Q. In looking at your curriculum vitae, I saw where you listed your organizations. There are a number of organizations for practitioners in pediatric infectious disease, correct?

A. There's actually only one society.

Q. Well, there is the American -- first and foremost, the American Academy of Pediatrics is more pediatrics, correct?

A. It's all pediatrics.

Q. You are not a member of that, are you?

A. No, that's not true. I've been a fellow since 1973.

Q. Not on your curriculum vitae though?

A. It is. I think it says board certified in 1973 and fellow

since 1974. If so, that's an error.
Q. You are not a member of the Infectious Disease Society of America, are you?
A. I am not a member of the IDS.
Q. You are not a member of the Pediatric Infectious Disease Society, correct?
A. I was for 15 years and stopped paying dues.
Q. In terms of your infectious disease work, looking at your curriculum vitae, I didn't see that you are a hospital epidemiologist; would that be true? You don't hold that position?
A. Right. While I was at CDC, the program I was in was called the laboratory division, and I was not in the academic intelligence service.
Q. Currently, at any of the hospitals you practice at, you are not the hospital epidemiologist; is that correct?
A. That's correct. One of my partners is.
Q. Looking at the various articles that you wrote, I didn't see any on there that were particularly pertinent or that dealt with E. coli infection; would that be correct?
A. That would be generally true.
Q. So it doesn't appear that you've ever written on the subject specifically E. coli infection. Do you do any research, Doctor?
A. Not anymore. I did extensive research for 13 years.

Q. And you had never researched on E. coli infections either; would that be correct?
A. That's true.
Q. In terms of your testifying while Mr. Colville was asking you questions, I added up the numbers, and it looks like that you have reviewed, over the course of your career, about 1,200 or more cases. Does that sound accurate, reviewed?
A. No.
Q. You said you did 36 -- 35 years at 36 a year?
A. No. I didn't say that. That misstates my testimony. That's more recently. When I started, I was only getting five to eight cases a year.
Q. Okay.
A. And the number of cases, I would say, I've given by deposition -- one of the lawyers counted 225 depositions in March, so I would be up to about 230, 236, and I routinely do not give depositions that go to trial, about half the cases, so I would say 500.
Q. You've reviewed 500 cases; is that correct?
A. About 500.
Q. Mr. Colville had asked you some questions about the states that you testified in. I've actually done some research and found some information that you've actually testified in 29 states.
A. I think I've testified in more than that actually.

Q. You think more than 29 states?
A. Probably.
Q. So both he and I are missing a couple of states?
A. I think so.
Q. So you have literally testified sea to shining sea; would that be true? Coast to coast?
A. I've gone beyond the coast. I've testified in an Alaska case. One, perhaps two, Hawaii cases. To my knowledge, never in California. Once in Washington.

MS. KOCZAN: Thank you, Doctor. Those are all the questions I have.

THE COURT: Mr. Price, anything further on qualifications?

MR. PRICE: No.

THE COURT: Well, the court now accepts the plaintiffs' proffer. Dr. Shore will be testifying as an expert in this case, particularly in the fields of pediatrics and pediatric infectious disease.

Go ahead, Mr. Price.

MR. PRICE: Thank you, Your Honor.

DIRECT EXAMINATION (Resumed.)

BY MR. PRICE:

Q. Dr. Shore, this came up yesterday, too, and I know that the government brought up this question. So you've never practiced here in Pittsburgh or Beaver County.

From your understanding of the standard of care in medicine, is it a local standard of care that is limited to Beaver County, or is the standard of care you testified nationwide?

A. It's nationwide. There's a few states that have some peculiar regional qualifications like North Carolina and to a lesser degree Tennessee, but a great number of states say there's a national standard of care and there is one.

Q. That's what you are going to be testifying to today here?

A. Yes.

Q. I'm going to ask you about a few rules the jury has seen. I just want to make sure if you agree with them. First rule, if a baby is at risk, a pediatrician must be present at delivery. Do you agree with that?

A. Yes. If a baby is at risk, either a pediatrician or a neonatal specialist such as a NICU nurse or a NICU that is neonatal intensive care unit respiratory therapist.

Q. Second rule, a hospital must take all precautions to minimize risks to its patients. Do you agree with that?

A. Absolutely.

Q. And the final rule, the earlier you treat something, the better the outcome?

A. Yes. That would be true except for some very advanced cancers and things like that.

Q. And the earlier you treat something, the better the

outcome is in most particular to your testimony here today?
A. Right. It would be very true for infections.
Q. Now, I'm going to move along to the medical definitions, and I know the jury has heard a lot about this, but I just have to make sure they understand where you are coming from.
Meconium, what do you look for when meconium is present during labor?
A. What's typically done is you look to see what the meconium is like, whether it's thick or thin. We will usually -- we have to clear the baby's mouth and upper airway with suctioning and the like, and we look, if we think there's a chance that the baby is in any kind of distress or the baby may have swallowed some of the meconium, this can cause obstruction to the airway or even infection in the lungs, and so what one does is you look down with a laryngoscope, which is a curved blade, and you look to see whether the meconium has traveled beneath the vocal cords.
Q. Can you tell us what is meconium aspiration syndrome?
A. In this case, a baby is generally in distress in utero for some reason either being deprived of oxygen or suffering from an infectious process or some traumatic event, and the baby puts out meconium into the amniotic fluid. In other words, it has an involuntary bowel movement, and then in the process of having stress, the baby can take a gulp in and inhale some of this material which may or may not get as far as the lungs.

Q. Another medical issue is E. coli infection. Can you tell us what is an E. coli infection?

A. Well, first, let's say what E. coli is. E. coli is the dominant aerobic organism in the bowel. We all have it in our bowels. Pretty much all women have E. coli in their vaginas. So E. Coli has the ability to move to different places, and it can move up and get into the placental plate and into the amniotic fluid and cause infection that way. It's a -- it's called a gram negative rod. It's the second leading cause of neonatal sepsis.

Q. And what is sepsis?

A. So sepsis is when a baby generally has a fever or low temperature, a baby has an immunologic response to it in terms of its white count and certain parameters such as C-reactive protein, and most importantly, generally a germ can be isolated from the bloodstream on blood culture.

Q. Another term we heard just briefly, can you tell us bronchopneumonia, what is bronchopneumonia?

A. Pneumonia is considered an infection or at least an inflammation of the lungs, and broncho means the pattern is uneven, scattered around the different bronchial tubes, which are the big air pipes that go to the different parts of the lungs. Rather than seeing one complete area involved, which we call consolidation, bronchopneumonia is a more uneven pattern usually across both lungs.

Q. The cause of bronchopneumonia can be an irritation in the lungs?
A. Irritation of the lungs, infection of the lungs. It could be either.
Q. Here's a new slide that I made for you, and the jury hasn't seen this one yet so it's something new. So could you show or tell us what we're looking at here, and I know that from talking with you, there's at least one correction or one point you want to make with regard to the right-sided infant. If you tell us what we're seeing first on the left side?
A. On the left is a normal situation where baby does not have any meconium inhaled. Actually, it shows -- it does show actually a little aspiration here in the very beginning. This is normal where there's no meconium that the baby has inhaled.
These are the little air sacs where the blood goes right by the air sacs. Oxygen is taken in and carbon dioxide is taken out by the interaction of the air sacs with the blood vessels. So you want those open. Okay. That's the normal situation.
So oxygen is exchanged across the alveolar -- these sacs are called alveoli. These are the alveolar walls. The capillaries take it up and that's how we breathe. We breathe in oxygen and breathe out carbon dioxide through these sacs, and the blood vessels either discharge carbon dioxide or take up oxygen, and then the lungs will look like this except, in

this case, a baby has inhaled some meconium. Right there, there's not a lot, and it's mostly in the upper airway.

Q. Let me just ask you about that. Are there a lot of births where a baby can just take meconium into the throat area and not deep into the lungs?

A. Right. That's why I mentioned that sometimes we look down via a laryngoscope into the vocal cord area and see if there's material there and also to see if we can suction material out from below the vocal cord so the baby won't breathe that in.

Q. Let's go to the right side of that picture. Can you explain to us what we're seeing there?

A. So here what happened when the actual meconium gets into the lungs, the air sacs will fill up with meconium, and sometimes meconium actually carries with it or through secretions a germ, so either the germ or the meconium can be in there and the meconium blocks the oxygen uptake into the capillaries and also blocks the letting go of the CO2 that comes out of the lungs, so you can get a deficit in the amount of oxygen in your blood vessels and a buildup of carbon dioxide in your vessels, which are not very good.

The other thing that can happen is the meconium gets into the airways. Where this thing needs a little corrected, it makes the lungs look small. Actually what happens is the meconium gets into the airway, and oxygen and nitrogen, part of what we breathe, gets in, but it can't get back out when

the baby exhales, much like a ball valve works, so the baby's lungs actually blow up a little bit and the like, so it's detrimental for that meconium to be in the small airways, and it's detrimental for the meconium to be in the alveolar sacs where the oxygen exchange occurs.

Q. So just to make sure I understand, whenever we breathe in oxygen, we take it into our lungs and it goes to the bottom of our lungs through alveoli?

A. Not actually the bottom. It's all over the lung, but it's the edge of the lung. It's the fine parts of the lung that you can see on microscopic cross-section.

Q. And those fine parts of the lung is where the blood exchanges oxygen, takes the oxygen?

A. Correct. It goes across the alveolar wall and into the small capillary.

Q. Those same walls accept the carbon dioxide to get rid of it out of our body?

A. Exactly. We need both to go on. So one is called oxygenation, that's getting in the oxygen, and the other is called ventilation. That is getting off the carbon dioxide.

Q. If there's meconium there or a block there, that impedes that oxygenation ventilation process?

A. Exactly. Both processes. Oxygenation goes down, which would be measured by the blood oxygen, and blood CO2 goes up, which is a function of the diminished ventilation.

Q. And whenever you have, I guess, increased carbon dioxide in your bloodstream, what does that do to you?
A. That makes your blood go acid, which is detrimental to the body.
Q. And I know you say detrimental, but what can happen to you if you have too much carbon dioxide?
A. Too much carbon dioxide makes the brain go to sleep. It causes what we call narcosis.
Q. Next, I want to ask you about this. I put them side by side here. I want to ask you. Can you tell us the relationship between meconium and a condition like bronchopneumonia?
A. If you inhale enough meconium, it will look just like bronchopneumonia. You won't be able to tell bronchopneumonia from meconium from bronchopneumonia from a germ E. coli, and in fact, as I think occurred in this case, both happened.
Q. Can you have -- I mean, can meconium ingestion cause bronchopneumonia?
A. Yes.
Q. I know I showed this, and again, you agree the earlier you treat these conditions, the better?
A. Absolutely.
Q. Okay. Now, I asked you to review some material in this case and you had a chance to review the medical records and depositions and hospital policies?

A. I had everything there. I don't recall being sent hospital policies.

Q. Yes. I don't know if I did. We're going to talk about the facts of the case and your concentration really occurs at the time of delivery. So this baby was born by vacuum extraction at 5:20 a.m. 2014 on October 13. Do you recall that?

A. Yes.

Q. What do you remember about review of the records for that?

A. That the baby was born by vacuum extraction. The baby weighed about four kilograms, I think about eight and a half pounds. The baby had reasonably good Apgars. They weren't perfect.

The first Apgar, which is a measure of the baby's vitality, basically its oxygenation, was a six, which is slightly depressed.

The second Apgar -- the first is done at one. The second one is done at five. The one at five was okay. It was eight, so the baby had a suspicious first Apgar but a normal second Apgar.

Q. What about the amniotic fluid?

A. The amniotic fluid was found to be stained with meconium, and the baby itself was actually stained with meconium, so that meconium had been in the amniotic fluid long enough to turn the color of the baby's skin.

Q. You noticed the -- and the jury has seen the Apgar score and the assessment in the first ten minutes. Did you notice from your review of the records any assessment of the baby from 5:30 until 7:00 in the morning?

A. No, I did not.

Q. Now, at 7:25, we've all seen the record, 81 percent oxygen. Did you see that?

A. Right. That was the pulse oximetry, so that's the saturation of the oxygen measured by that little pink thing they put on the baby's toe probably. For us, it would be a finger.

Q. 81 percent, is that a normal oxygenation rate?

A. No. It's low. You would want it to be at least upper 80s, maybe 89. 90s would be better.

Q. After that, did you review the records with regard to what happened next?

A. There is allegedly -- well, the baby was placed in oxygen. The nurse, I believe, at 7:20, testified that she found the baby in some distress and put the baby in an oxygen hood so the baby could get more oxygen.

It is then stated, and it's unclear, that the pediatrician was called, although the pediatrician herself said she did not get a call at about that time.

Q. Was there any -- do you see in your review of the records any other doctors, anybody, any residents examining the baby?

A. Yes. According to the resident's testimony, he saw the baby at about 8:00, after which he had been attending a lecture. I imagine on some pediatric topic.

Q. And did you see the care that he gave to the child or his assessment?

A. I think he agreed with the oxy hood and preferred to wait until the pediatrician, Dr. Jones, arrived.

Q. And can you tell us at 7:25, whenever the nurse was examining this child, how was this child besides the oxygen rate? Did she make any notes with regard to how the baby was handling things?

A. Yes. The baby was using accessory muscles. Normally you can't see breathing very well. This baby was retracting, so you could see the part above her trachea -- the part above the sternum, excuse me, pulling in. You could see the ribs going, and there was retractions, probably seesaw respirations where you could see the stomach moving in and out. We call it seesaw.

Q. If a baby is wrapped up, could you easily see whether or not there's retractions of breathing?

A. No.

Q. You can't?

A. It would be difficult unless it came below this part here (indicating) which is called the suprasternal notch, but it is usually covered, you probably wouldn't see it.

Q. If she was covered, you probably wouldn't see it?
A. Probably would not see it.
Q. Dr. Jones showed up at 8:15, and can you tell us what was her assessment of Kendall whenever she got there?
A. She was alarmed. The baby looked sick. She ordered laboratory tests to be done. She ordered a capillary blood gas, which is a finger prick, to look at the baby's level of oxygen and carbon dioxide. She ordered a chest x-ray and she ordered a blood culture. I don't think right at that moment she ordered antibiotics, but she may have.
Q. If you could pull up tab 6, Page 19, and these are the blood count records from Kendall, and I know that you have made some reference in your report to them and if you could just --
A. Okay. The parts of the complete blood count which gives lots of information, it gives information on whether the baby is anemic. That's the hemoglobin and hematocrit.

It shows you how many white blood cells are there and what kind of white cells are there. Those are the cells that defend your body against infection and it also shows things like the platelet count. Platelets are little bits of a larger cell called a megakaryocyte. These carry clotting factors and keep us from bleeding to death.

So what this shows is the white count actually is slightly low. This is for age. In a newborn, the white count, the low

white count is 9,000 and the upper limits of normal is 30. The baby's white count is slightly depressed. The hemoglobin and the hematocrit, you can take my word for it, are normal, and the platelet count at 180,000 is normal.

Q. And from your review of these records, can you tell us what do these show you with regard to the condition of Kendall at 9:00 in the morning?

A. Okay. So to more fully explain that, we need the differential.

Q. It might be above that.

A. I think it's right there. Is that a three there?

Q. Yes.

A. So the number there is segmented neutrophils. These are the gobbler cells. These are the cells that eat bacteria. When you have a bacterial infection, you need a lot of them. We like to have at least 1,500 or something like that total.

This baby -- so the number of neutrophils should have been at least 60 to 70 percent, 55 to 70 percent. It's only three percent.

When you multiply the number of the segmented neutrophils times the white count, you come up with 250 gobbler cells per unit of blood, which is very low and leaves the baby almost defenseless against infection. It makes the chances of survival go down.

Q. Okay. So that tells you how the baby's own body and blood

system is able to fight off infections?
A. It means it's been trying to fight it for some time. Perhaps 12 to 24 hours before the baby came out of the womb and got delivered.
Q. Okay. Anything else from the differential or the blood test results?
A. So we go on to the previous page, the one that had the platelet count, it may be in there somewhere. There they are. Those are normal. So what happens when you get an overwhelming bloodstream infection, generally speaking, first the white blood count goes down, then the neutrophils go down, and worst of all, the platelets go down which leads to a process of bleeding in different organs called DIC, disseminated intravascular coagulation. It usually takes longer for that to come.

So I would say this was a developing -- it was a developing infection. It was getting on to the severe side. It was not to the point where the baby was going to bleed to death from the low platelets. So let's say a well-established infection but with a saveable baby but with concern for survival because of the low white count and differential.
Q. Okay. If we could pull up tab 6, page 22, and that is a copy of the chest x-ray that was taken of Kendall at 8:52 in the morning. And again, I know that I don't understand all this, so can you tell us what does that show you?

A. Sure. So normally, when you look at the lungs, the lung fields look mostly gray, and there's some wisps of white which indicate blood vessels and bronchial tubes.

Here there is additional white material at the right base which is the base of the right lung. There's an area of consolidation which means either pneumonia or a process we call atelectasis, where the lung can't re-expand such as the meconium got caught there. It also has a small right-sided effusion. That would be unusual for meconium but would not be uncommon for pneumonia like E. coli.

Then they also noted right apical consolidation. Apical means the top of the lungs, the apex. There's consolidation noted there and then there are air bronchograms at the right medial base. Again, that suggested there's something going along the bronchial tubes that's consolidated that makes the bronchial tubes stand out. Those are called air bronchograms.

Then there are other, what we call, infiltrates or densities in the perihilar area. That's where the main bronchial tubes come off, but it spares the lung peripherally on the left, so basically what they're agreeing it says it looks like a meconium aspiration or neonatal pneumonia, you can't tell them apart, and it's uneven, affecting a little more the right lung than the left.

Q. So at least with regard to this time from the x-ray, the

radiologist, whenever he's looking at it, he sees something in the lungs. It's just that on the film, he can't tell if it's pneumonia or meconium?

A. That's correct. It will look pretty much identical.

Q. And the only way that you can really tell would be through an autopsy?

A. Well, the blood count gives you a hint that there's infection because meconium aspiration is not going to lower your white count and your neutrophil count, so I would say sepsis is definitely present.

Whether or not there's meconium present or not, you would have to probably wait until autopsy to know that for sure.

Q. The next x-ray is taken at tab 6, page 23, and this one was taken an hour and a half later, and this is whenever they put an endotracheal tube down Kendall's throat into her lungs, and the findings were done to make sure that it was properly placed, but they also noticed some other things.

A. Right. So now there's more white areas. This is called an extensive consolidation. This means that airways have collapsed, and the lung is not getting ventilated as well. It could also mean there's more pneumonia building up that looks like fluid inside the lung tissues. It has a patchy heterogeneous appearance. Again, there are air bronchograms which we had discussed before.

So now it says there's an extensive neonatal

involvement. It could be related to meconium aspiration, but it could be an extensive pneumonia as well. You can't tell them apart.

Q. You had a chance to take a look at the care that Dr. Jones and the transport team provided to Kendall, and I would ask if you could summarize what they did and what Kendall's condition was over the next hours that she was under their care?

A. Right. So the thing has really got bad. Dr. Jones came back at around 9:15, I believe, and said the baby had deteriorated in the oxygen hood.

She then took a look at the baby. She repeated some of the gases, which showed more carbon dioxide buildup and less oxygen, and she was unable, I think, using 100 percent oxygen to ventilate the baby properly and give it enough oxygen. So she decided, slightly before the transport team from West Penn came, to intubate the baby. The baby at that point was getting very sick.

I don't think at that time the baby was hypotensive, meaning having low blood pressure, because I noticed that no blood pressure medicines were started, but the baby's lungs were clearly deteriorating and the baby was losing the ability both to bring in oxygen and send out carbon dioxide.

Q. Did they provide medications and did they try to help this condition in any way?

A. Yes. They tried intubating. They gave the baby an agent

called nitrous oxide -- nitric oxide, which tends to make blood vessels in the lungs dilate. Pardon me, but it's a little bit like Viagra which does the same thing. We actually use that in the NICU.

It's to make the blood vessels wider so there would be less likely that the baby won't take up oxygen and carbon dioxide and less likely that the baby will bleed into the lungs as it subsequently did.

They also adjusted pressures and tried to ventilate the baby the best they could and to start antibiotics as well.

Q. And I mentioned a drug called surfactant. Was that used? Can you tell the jury what that was?

A. Yes. Surfactant is something that makes a balloon easier to blow up basically. When you blow up a balloon, initially it takes a lot of pressure to get it going. There's some physical principle. If you were to have surfactant in there, your little bit of puff would get the balloon open quickly. That's surfactant.

Q. And then did you see the medical records with regard to whenever her heart rate dropped, and the last hour, what they did for her?

A. Right. Her heart rate dropped below 100. This was about, I think 10:50, 10:55. They started chest compressions and then gave her blood pressure medications and the like and they kept giving her -- I think you all know what CPR is. They did

CPR on her for, I think, 45 minutes and they could not revive her.

Q. Did you also have a chance to review the autopsy report in this case?

A. I did.

Q. And what did that -- what information did that provide you about Kendall in this case?

A. Well, like the blood that grew out E. coli subsequently, a culture of the lung also grew out the same organism, E. coli, so the cause of death was felt to be septicemia and E. coli and pneumonia from the E. coli which occurred together.

The lung tissues seemed to show areas of pneumonia with inflammatory cells which could indicate just bacterial pneumonia, but at least my reading of it was there was definitely some meconium to a moderate amount of meconium in the lungs.

So I think the pathologist concluded that the baby both had a neonatal pneumonia infection and also had meconium aspiration.

Q. Can you tell us what the relationship -- how did the meconium affect the E. coli and the bronchopneumonia?

A. Okay. So that's a very good question. Mechanically, what probably happened, and we have the white count to show that somehow during labor in the previous 12 to 24 hours, E. coli gained access to the baby either through the amniotic fluid or

through some small tear in the amnion and caused an infection that got into the baby. The baby then did well for a while but then made a gasp and delivered some meconium into the amniotic fluid which the baby then inhaled.

Q. And how did the fact that the baby has now ingested the meconium fluid, does that affect the baby's ability to deal with or fight off an infection?

A. It's like adding, you know, the effect of one atom bomb to another atom bomb. You've got two basically potentially fatal syndromes going on at the same time.

Q. Now, as a result of your review of the records and examination of the studies and the tests and reports, did you come to an opinion in this case?

A. I did.

Q. And I'm going to ask you about your opinions. You just talked about the fact that you believe it's highly likely that the baby became septic during labor and delivery which led to the meconium aspiration?

A. Right. I think the infection came first, and that was the stressor that made the baby put out meconium into the amniotic fluid and then inhale it.

Q. Then you talked about the septic process. Can you explain, is there anymore you want to add with regard to you said a low A and C count, septicemia, depressive bone marrow.

Can you tell us a little bit more about your opinions

there?
A. Right. So the baby then goes into septic shock and what's called multiorgan failure, where different organs, because they are not getting adequate oxygen, stop doing their work, organs like the liver, kidney, especially the brain so the baby losses consciousness.
This is all going on to interrupt the process you have to get antibiotics in as quickly as possible to stop that and also support the baby's circulation and things of that sort.
Q. Again, this is getting deep into the medicine, but you noted that the normal platelet count and the CBC, did that suggest anything with regard to the septic process?
A. The septic process would have been ongoing at the point that the white count and differential were measured which was about four hours after the baby was born. The white count and the differential would undoubtedly have been better had it been measured, let's say, in the first 30 to 45 minutes of life.
Q. The baby came out and we've heard that the baby had normal Apgars. Does that give you any insight into this infection and how it was progressing?
A. At that point, the baby was what we call compensating for it. The baby had a slightly low first Apgar but a good second Apgar, so you would say, well, this is almost normal. The

baby's color was good because the Apgar has -- part of it is a score for color so the baby looked, at least at delivery, relatively good.

Q. Do you believe this baby was sick at birth?

A. The baby was sick, but it would take a little more time for it to be evident over the next hour or two just how sick this baby was.

Q. In your opinion, could Kendall have recovered with prompt medical care in the first several hours of her life?

A. Yes.

Q. Do you believe that a pediatrician should have attended this delivery?

A. Either a pediatrician or in our hospital someone from the neonatal intensive care unit.

Q. Why?

A. Because you not only have to evaluate the baby, but you have -- some professional has to be there who knows how to plan for the subsequent care which may involve NICU-type care, transfer to another hospital, intubation. The earlier you do things for a baby like this, the better the outcome.

Q. Do you believe that whatever chance Kendall had of surviving, the chance was lost by not having a pediatrician attend the delivery?

A. I think that was a major contributing factor.

Q. Do you also believe whatever chance Kendall had of

surviving, that chance was lost by not having a pediatrician notified about the baby and the respiratory distress immediately?

A. Yes.

Q. Would that have allowed more time for what?

A. For the evaluation of the baby first, for the blood work to be done and more time for the antibiotics, in this case ampicillin and gentamicin to have been given, to support the lungs while they were going down.

Q. From your review of the records and the culture that grew, were any of the antibiotics that would have been prescribed for Kendall, were they sensitive to this E. coli bacteria?

A. Well, it's the reverse. The bacteria would be sensitive to the antibiotic. 50 percent of E. coli are not sensitive to ampicillin which is one of our go-to drugs in the newborn, and they are all pretty much sensitive to gentamicin, so the baby would have responded to gentamicin had it been given promptly.

Q. And would the more time, the administration of gentamicin and other appropriate interventions given Kendall more of a chance to survive?

A. Yes.

Q. What about the facts that the neonatal team didn't arrive until 9:45 a.m., about four and a half hours after delivery? Do you think there was any lost chance or any lost time because of the delay in getting them there?

A. Definitely.
Q. How is that?
A. Again, earlier treatment supported the lungs, giving the antibiotics and just knowing what to do in that situation. Having been a primary care pediatrician, what this baby presented with strikes terror in the hearts of pediatricians. We don't see it very often. Newborn sepsis like this in a term baby only occurs in like one in a thousand babies on average. It's not something we face often and it's not something we want to face.

Also, the doctor had another sick baby at the time, so she really had quite a morning.

Q. Right. And we're going to hear from her about that, but there were two babies she was dealing with that were going to get LifeFlighted that day.

E. coli infections, are they treatable or can you deal with them in a newborn?

A. Yes. E. coli is one of the more dangerous germs you can get from what's called early onset sepsis. The other one is called group B strep. E. coli is more dangerous, but the majority of babies with early onset E. coli septicemia survive.

Q. You said majority. How often -- I know one of the defenses in this case is that this E. coli infection has a high mortality rate.

A. It does compared to other infecting agents, but the latest data I saw was about six to ten percent of all early term white babies infected with this agent, so six to ten percent of the reported cases, died. The rest survived.
Q. It's been suggested that there wasn't a massive aspiration of meconium and meconium played no role in Kendall's death. Do you agree with that?
A. I do not, but you just have to treat both of them. I don't think it makes a material difference either way.
Q. Do you believe that this disease process could not have been reversed by earlier administration of antibiotics?
A. I don't believe that.
Q. Well, there were no risk factors or clinical symptoms present during labor. Do you agree with that?
A. My understanding is prior to that, there were -- there was meconium in the amniotic fluid and that constitutes a risk factor.
Q. Again, if a pediatrician was present, do you believe that a pediatrician would have been able to at least recognize or at least been attuned to any type of respiratory issues?
A. Yes. I think you would say, if this baby turns a hair, you give me a call and we'll start a process. Some places have protocols to handle this type of respiratory distress. Do X, Y and Z. I didn't see any protocols, but a pediatrician called to a delivery at 5:20 a.m. is going to say please call

me if anything happens. They give a list of things to watch for, chief of which is respiratory distress.

Q. Was there any watching of this baby over the next hour and a half?

A. None that I could find in the records. I think the baby was bonding with mom.

Q. Have the opinions that you've expressed here today been expressed to a reasonable degree of medical certainty?

A. Yes, sir.

MR. PRICE: That's all the questions I have, Your Honor.

THE COURT: Okay. Cross-examination, Mr. Colville.

CROSS-EXAMINATION

BY MR. COLVILLE:

Q. Maybe we'll begin where you began.

MR. COLVILLE: Doug, can I get the demonstration of the two lungs in the first question to the doctor.

MR. PRICE: Yes.

Q. Before we go there, one of the last questions, you were asked about symptoms and signs. Dr. Zamore who testified on behalf of plaintiff as the OB expert in this case, he testified yesterday and he testified that there were no signs or symptoms of an infection during the prenatal course of Carissa. Do you agree with that?

A. I didn't see any evidence in anything I was sent that

there was a sign of infection during the prenatal course.
Q. He also testified that there was no sign or symptoms of an infection, any infection during the labor and delivery. Do you agree with that statement?
A. Yes.
Q. He also testified that the delivery assessment which documented the birth and the condition of the baby once delivered also indicated no signs or symptoms of an infection. Do you agree with that?
A. The Apgar six is a little suspicious, but that would be a very soft sign and not particularly predictive.
Q. You essentially agree there was no sign or symptom of infection at that point?
A. Based on the testimony and the records at the time of delivery, yes.
Q. So when that baby was handed off to the nursing staff to perform the Apgar testing and do the assessment, nobody standing there would have expected or should have been expected to think that the baby had an E. coli infection at that point based upon its presentation; is that correct?
A. Either E. coli infection or meconium aspiration at that point.
Q. There was no reason to believe that or to anticipate it?
A. It would be possible with the passing of meconium that that could happen, but most times when babies pass meconium

and they are term babies, they don't get meconium aspiration syndrome.

Q. There was no symptom or sign there was a problem at that point either, was there?

A. Correct.

Q. Which leads us to this demonstration. You indicated the baby on the left which indicates a normal condition; is that right? Is that right?

A. At the bottom left, yes, because above, it shows the baby has some meconium in the airway.

Q. That's the point. I mean, it's not uncommon for a baby that is delivered vaginally to have some meconium in it; is that right? There's thick and there's thin; is that right?

A. That's correct.

Q. Now, this one on the left -- this one on the left exemplifies more likely thin meconium as opposed to thick; is that right?

A. I don't think it really states. I couldn't interpret that as whether it's on its way down into the alveoli or not. I can't comment on that via the illustration.

Q. Well, if you look to the one on the right, which is the fetal distress version, on the bottom, it specifically references thick meconium, right?

A. Right. It shows the alveolar sacs involved. This one does not suggest that the alveolar sacs are involved.

Q. The fetal distress on the right is indicative of thick meconium?
A. Correct.
Q. In contrast to the one on the left which does not have thick meconium?
A. Right.
Q. The one on the left that does not have thick meconium is a normal delivery, even in the presence of some meconium; is that correct?
A. At least at that point, if the meconium was just to stay there, the lungs look like that, yes, that would be correct.
Q. Now, in this case, are you assuming that the meconium that was found was thick meconium?
A. I'm not assuming that.
Q. You would agree that thin meconium is something that you wouldn't necessarily need or require to have a pediatrician present during the delivery to attend to?
A. I don't think it's predictive one way or the other. I think just the presence of meconium is considered an abnormality, and it's a fearsome abnormality if the baby is premature.
Q. This is something an obstetrician is trained to identify, to assess and to act upon; is that correct?
A. That's his job, yes, sir.
Q. You are not here in that capacity to testify as an expert

as an obstetrician?
A. That's correct.
Q. In this case, did you review the deposition testimony of Dr. Dumpe?
A. I do not think I was given that to review.
Q. You didn't review the doctor who delivered this baby's deposition?
A. I don't think I was sent that. It's not in my records.
Q. Did you request it?
A. This was quite a number of years ago. I don't recall.
Q. Wouldn't you want to know what the doctor said about his thought process in a case?
A. I would like to know.
Q. Did you ask for it?
A. As I said, I don't remember.
Q. Is it your practice to ask for it?
A. Sometimes. Sometimes if I'm only asked to look at causation after the baby is born, it's more or less irrelevant from what I'm doing. I'm not being asked to see whether the obstetrician had done anything wrong. Just what the course of the baby was and when would intervention have made a difference.
Q. What the meconium actually looked like, what it really looked like at the time, what happened in this case is an important fact, don't you think?

A. It's a factor.
Q. There's two people who were there who saw it, Dr. Dumpe and Nurse Hendershot.
MR. PRICE: Objection.
Q. Did you read that deposition?
THE COURT: Sustained.
MR. PRICE: Objection.
MR. COLVILLE: I'll withdraw the question.
THE COURT: Slow down a little bit. One person at a time. You question. You answer. Let him get to the question mark. Let him get to the period.
Q. It's important to know what the meconium looked like in this case, correct?
A. I would like to know, yes.
Q. Now, we know that Dr. Dumpe was there when the prebag was broken, right?
A. Yes.
Q. And he saw it, right?
A. Yes.
Q. He described it, right?
A. That's my understanding. Yeah, because you would look at it and you would describe it as thick or thin.
Q. You would expect that a doctor like him who is being deposed would be asked questions about it, right?
A. Of course.

Q. But you didn't take -- you didn't think it was important enough to review that deposition transcript prior to testifying or prior to preparing your report in this case?
A. It wasn't what I was asked to do.
Q. Did you review Nurse Hendershot's deposition?
A. That was not given to me either.
Q. Did you ask for it?
A. No.
Q. Do you know that she was present during the labor and delivery?
A. I do know that.
Q. Do you know that she documented what the meconium looked like?
A. I would think she would.
Q. Wouldn't it have been an important thing to review her deposition to form an opinion in this case?
A. Not really. The E. coli, I think, is the dominant part of what killed this baby, so it didn't seem to be relevant. If you don't take care of the E. coli and you have a massive infection with E. coli, you are dead.
The meconium is really not the most important thing. It's important as an indicator of possible distress, but I think the most important thing is the overwhelming infection.
Q. We agree on that. We agree that the E. coli is the problem here. That's what killed the baby. Do you agree with

that?
A. I think most of the killing came from the E. coli and the septicemia. Yes, sir.
Q. Bring up Exhibit 6, page 10. This is the delivery assessment that we were talking about earlier, with the Apgar scores. Right here, the meconium that was present was indicated as thin meconium.
Would you agree that thin meconium is better? It's better to have thin meconium than thick meconium?
A. Yes.
Q. That thick meconium is what you've described as a massive aspiration of meconium?
A. Right. You could aspirate thin or thick, but thick would do more damage because of its viscosity, its thickness.
Q. In this case, meconium is described as thin, right?
A. Correct.
Q. And you've reviewed the labor records in this case?
A. I was not given the labor records to review.
Q. What records were you given?
A. I was given the post natal records, starting about here.
Q. You don't know how the meconium -- how it presented during labor or how it was described during the labor?
A. I know it was described as thin.
Q. Only from this document?
A. That seems to be an adequate document to say thin.

Q. I agree.
A. Okay.
Q. Did you see any medical records that indicated whether or not the meconium was particulate?
A. No.
Q. Do you know if it was particulate or not?
A. No.
Q. Is that an important factor that you would want to know in deciding what type of meconium was present?
A. Not really, in the context that this baby had an overwhelming infection.
Q. Is that because -- I guess that's the point. You are more concerned about the E. coli in this case than you are the meconium?
A. One reason I'm a witness here is because it's an infection, sure.
Q. Based upon the findings of this -- well, this document, the delivery assessment is a snapshot of the baby's health once it's been delivered; is that right?
A. Correct.
Q. You've indicated the Apgars of six and eight. Eight is a normal finding; is that right?
A. Right.
Q. In this case, you also indicated you didn't see the hospital policies in this case?

A. No, I did not.
Q. You didn't see any of them?
A. That's correct.
Q. One of the hospital policies allows babies to be left in the room with the mother and father to bond if an Apgar score is seven or above. Does that make sense to you? Does that sound normal?
A. As a guideline, yes. There are always exceptions to guidelines, but yes.
Q. In this case, the baby was an eight. In your opinion, it was a normal, healthy baby, and it's appropriate to give to the parents for bonding?
A. Yes.
Q. Now, also on this document, there's a delivery assessment that goes through basically head to toe whether or not there's any abnormalities presented at the time of birth.
Do you see that?
A. Yes.
Q. You would have reviewed that prior to testifying here today?
A. Yes.
Q. And there were no abnormalities found; is that right?
A. Correct.
Q. There were no -- an abnormality would be a symptom of respiratory distress?

A. That would be considered an abnormality, yes, sir.
Q. If a baby was grunting, you would expect it to be noted in this portion of the document, right?
A. Absolutely.
Q. And it was not?
A. Yes.
Q. In fact, there were no abnormalities? There were no symptoms of respiratory distress noted?
A. Correct.
Q. At this point, if -- let me pull back on this entire document. Dr. Zamore, when I asked him about whether there was symptoms, like I did with you, you indicated there were no symptoms up through this assessment. I asked him, I said is this the snapshot of a healthy baby. He said yes.
Do you agree with that?
A. Yes.
Q. So at this point, what would a pediatrician have done if a pediatrician had been called when there are no symptoms of an infection or any symptoms of meconium aspiration?
A. What you would do, if the pediatrician was called and there was a concern because of the meconium, you would say to watch for signs of meconium aspiration syndrome, not infection. That's what you would do.
Q. But in this case, there are no signs of that at all, are there?

A. If the pediatrician was called because the risk was increased and meconium was found, then that would be the reason to ask a pediatrician or a higher level person, NICU person. Then you would say please call me if the baby develops any respiratory issues.

Q. But the decision as to whether meconium poses a risk is not on the pediatrician under hospital policy. Are you aware of that?

A. No, but I'm not sure I would agree with that policy.

Q. But in this case, the obstetrician who was there when the meconium was presented and the nurse who was there when it presented, did not believe it posed a risk sufficient enough to call a pediatrician because it was thin. That's what the testimony is in this case.

A. Okay.

Q. Does that make sense to you?

A. It's one way to look at it, yes. There are hospitals that require people to be there for any meconium in the in utero process.

Q. In this case, the obstetrician at issue was Dr. Dumpe and he has over 30 years of experience dealing with babies during deliveries who present with meconium.

A. I'll accept that.

Q. And you do not have that experience.

A. I'm not an obstetrician, yes, sir.

Q. At this point, which is 5:20 to 6:00, this assessment that was completed, a pediatrician would not have been expected to prescribe antibiotics for anything?
A. Right. Yes. Well, the timing on this, it would depend when completed, but at this point, yes, you would not prescribe antibiotics.
Q. You don't prescribe medicine for a baby who doesn't present with symptoms; is that right?
A. As a rule.
Q. When is the first symptom of respiratory distress in this case documented in the medical record?
A. It's not documented until the note of 7:20 by Nurse McCrory.
Q. But that's the first documented note that the baby was having a symptom?
A. That's the first documented note.
Q. And that documented note indicates that the baby was grunting?
A. Correct.
Q. So between 7:25, which is the time, and 5:20, there was no documentation of any symptoms that a pediatrician would have acted upon; is that correct?
A. As I recall, there's no documentation of anything.
Q. And certainly by the time this document is drafted and prepared, Dr. Dumpe is out of the picture, he's done, he

delivered the baby, and the baby is healthy?
A. True.
Q. Did you review any deposition transcripts in this case?
A. Yes. There are three or four. There were the -- I think there were two nurses who looked at the baby, reviewed the one from the resident and the one from Dr. Jones, who is the pediatrician.
Q. So you did not review the deposition of Dr. Min?
A. No, I did not. I read some comments about his thoughts about what he found, but I did not actually read his deposition.
Q. Why would you prepare a report and not gather all the facts?
A. From the standpoint of the E. coli and the meconium, it didn't seem to be important. There was enough data there to come to a conclusion, and I don't ask for materials which I don't need, and it also runs up the cost of the investigation and the like, so I wouldn't.
Q. Do you do this in all your cases?
A. If I need a deposition to form an opinion, I will ask for one if it's withheld. Sometimes I'm given many more depositions than I even need to do, but I'll read them.
Q. How would you know what depositions are even out there?
A. I can usually infer that from the records. I would have assumed there would be Dr. Dumpe's deposition and something

from the nurse who was there. I mean, that's fairly easy to figure out.

Q. But the nurse that was there is a nurse by the name of Nurse Hendershot.

A. Yes.

Q. And part of what you've opined on here today is what happened between 5:20 and 7:25, right?

A. I certainly thought about it, yes.

Q. And Nurse Hendershot was the nurse who was attending to Carissa during that time, right?

A. Yes.

Q. So she would have had access to the room, to the mother and to the baby during that period of time, right?

A. True.

Q. And you didn't want -- you didn't feel the need to get that deposition to find out what she witnessed, saw, why she did what she did or why she didn't do what she didn't do?

A. There was nothing in the record to show that she saw the baby.

Q. Well, aren't there a number of visits by her that are documented getting the mom's vitals?

A. The mom's vitals?

Q. Correct.

A. Yes, probably.

Q. Are you aware that the room that the mom was in is where

the baby was delivered?
A. Yes. I've been told that.
Q. Are you aware that the baby was bonding in that same room for the period of time between 5:20 and 7:25?
A. I believe that's why the baby and the mom were together, yes, sir.
Q. If Nurse Hendershot came in every 15 minutes to see the mom, she would have had to have seen the baby?
MR. PRICE: Objection.
A. Not necessarily.
THE COURT: Sustained. Speculative.
A. It would depend on how the baby was clothed or dressed. If the baby wears a wrap and is bundled, a lot of times you will not see retractions because the blanket comes up usually close to the neck.
Q. Okay. That might be something that would be discussed in a deposition about her visits in and out, wouldn't it?
A. True.
Q. You chose not to investigate that or find out what was going on?
A. I don't keep track of all the depositions I'm given.
Q. But you knew that deposition was out there or would have been out there? You inferred it, I assume?
A. I knew it probably would have been out there, yes, sir.
MR. COLVILLE: I think that's all I have. Thank you,

Your Honor.

THE COURT: Well, ladies and gentlemen of the jury, we're going to take our midmorning break at this time. As with all the other recesses, you leave your pad and exhibit binder there on your chair, and once again, you are not going to talk about the case, not going to do any research, not going to communicate with anyone about the case. So let's take our morning break and we'll get back here at about ten to 11:00 and we'll hear some more from Dr. Shore.

Mr. Galovich, if you'll escort our jurors.

(Jury excused.)

THE COURT: Doctor, you may step down. During this break, you should not talk about your testimony with any of the attorneys, including Mr. Price. If you need to use the restroom, they are on either end of the hall.

THE WITNESS: Thank you, Your Honor.

THE COURT: Mr. Price, I see one of your witnesses has arrived. Is this the gentleman that needs to get to work? Are you going to call him out of order? What are you going to do?

MR. PRICE: Yes, I will probably call him right after Dr. Shore is complete.

THE COURT: Okay. You anticipate he'll be out of here in time?

MR. PRICE: Yes.

THE COURT: You don't need to call him out of order?

MR. PRICE: No.

THE COURT: Because Ms. Koczan still has cross. I'm presuming you might have some redirect.

MR. PRICE: Yeah, but --

THE COURT: You might want to ask him when must he leave the courthouse.

MR. PRICE: I know. And he has to be back at work by 2:00. But it's out in Beaver.

THE COURT: All right.

MR. PRICE: If she is going to be an hour on cross.

MS. KOCZAN: I don't know how long I'm going to be. I don't think an hour.

THE COURT: Could be long. In any event, if it's determined that you need to call him out of order so that he can make his work assignment, then you'll signal that, and as I reminded you all yesterday, I do have a meeting with probation that starts at noon and is going to go until about 1:15, so we are breaking from noon until 1:15.

THE CLERK: Brian screen mailed me. Ms. McCrory -- somebody from the U.S. attorney's called up. He had her sit in the hallway.

THE COURT: Nurse McCrory was floating around. Shaun Sweeney from your office apparently brought her up. They were back at the door peeping in. You may want to go find her.

She is somewhere in the courthouse.

MS. KOCZAN: She is one of the nurses.

THE COURT: I understand, but as I said, she was wandering around the courthouse. She got herself to the U.S. Attorney's Office, so to that end, Shaun Sweeney, who is another AUSA, saw fit to bring her up here. They were both peeping in the back door and they left. Where she is right now, I don't know.

MS. KOCZAN: I'll find her.

THE COURT: I would think you might want to do that.

(Recess taken.)

THE COURT: Ms. Koczan, you may examine.

MS. KOCZAN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. KOCZAN:

Q. Morning, Dr. Shore.

A. Good morning.

Q. I'd like to start where Mr. Colville left off. I think you had talked about that time period up to when the baby was in the room bonding, correct?

THE COURT: Ms. Koczan, the jurors are indicating that the jurors cannot hear you.

MS. KOCZAN: I can go over there.

Q. Dr. Shore, I'd like to pick up where Mr. Colville left off. I think when you finished speaking with him, we were up

to or you were up to the point of talking about what happened when the baby remained in the delivery room with mom, correct?
A. Yes.
Q. You've already told us that you have not read Nurse Hendershot's deposition, correct?
A. Correct.
Q. And you don't know what she had to say about her observations of the baby while she was in to examine Carissa, correct?
A. Right.
Q. You were not here yesterday when Nurse Hendershot testified, so you don't know what she had to say about that either?
A. Correct.
Q. Are you aware that there are medical records that indicate that she was in the room evaluating Carissa every 15 minutes?
A. Carissa being the mom?
Q. Carissa being the mother.
A. I'm not aware of that, but I'm being made aware of it now.
Q. You didn't see those medical records?
A. No.
Q. They weren't important for you to look at?
A. Not for what I was asked to do.
Q. But you were asked to evaluate the entire case, correct?
A. No.

Q. You weren't asked to evaluate the entire case in order to give your opinions here?
A. That's not how it was put to me.
Q. Okay. So anyway, let's talk about Nurse Hendershot then. She testified yesterday and I'm going to ask you to assume that she testified yesterday per her notes that she was in that room every 15 minutes, and while she was in that room every 15 minutes, she observed this child, looked at this child and did not see any evidence of respiratory distress. I'd like you to assume that she testified to that.
A. Okay.
Q. Now, you told us earlier that, well, if the baby is wrapped up, you might not be able to see retractions, correct?
A. Correct.
Q. But if a baby is grunting, that's something that you can see because that's not wrapped up, correct?
A. Well, it's something you can hear.
Q. That was my other point. You can hear it and you can perhaps see movement; is that correct?
A. I don't think you can see movement, but you could hear it if the baby was wrapped.
Q. And Nurse Hendershot testified yesterday she didn't observe any of that. I want you to assume that.
A. Okay.
Q. Also, if the baby is flaring, that's not something that

would be covered up either, would it?
A. That's true, but flaring is not that easy to see actually.
Q. Well, Nurse Hendershot had been a nurse for 30 some years. Would you assume that she had seen flaring before and might know what it looked like?
A. Probably, but I don't know that she looked for it. You can look at something and not see it.
Q. Well, she was there to look and observe and to see things, correct? That's the purpose of her being there?
A. Right, but I think she is a perinatal nurse, correct? She is the mom's nurse, correct?
Q. No. She is the nurse that was tasked with doing the initial assessment. It's her documentation that you have been looking at.
A. I understand.
Q. Are you aware of that?
A. Does she work in the nursery or the step up unit? They must have an area there. She works only in labor and delivery.
Q. Doctor, are you aware that she is neonatal resuscitation trained?
A. I'm not.
Q. Are you neonatal resuscitation trained?
A. No.
Q. But she is?

A. Okay.
Q. And that is something that, during the training, they would be taught to look for, correct?
A. I would think so.
Q. Now, you talked about no documentation there, but according to Nurse Hendershot, there was nothing going on during that time frame, and if there was something going on, it would have been documented, and she would have been done -- she would have done something about it. I'd like you to assume that she's testified to that.
A. Okay.
Q. Now, she takes the baby to the nursery at around 6:50, 7:00 a.m. Are you aware of that?
A. I was aware that the baby arrived in the nursery at about 7:00.
Q. Have you seen the vital signs that were done in the nursery at 7:00?
A. I think so, yes.
Q. Are you aware that those are normal vital signs?
A. Yes.
Q. Are you aware that when the baby got to the nursery, in addition to having its vital signs taken, she was also given eye drops and some Aquamephyton?
A. Yes.
Q. So again, the nurse is with the baby and has an

opportunity to observe the baby?
A. Yes.
Q. Have you seen Nurse Barb Hackney's deposition? Did you read that one?
A. I was not given that one.
Q. Nurse Hackney is the nurse who accepted the baby. You have no idea what she had to say about this baby at that time, do you?
A. No. What I recall is the nurse who took over at 7:20 said she was passed that baby by Nurse McCrory.
Q. Just so we are clear, you never read her deposition so you have no idea what she said about the condition of the baby?
A. That's correct.
Q. I'd like you to assume that she had testified during her deposition that that baby was fine when she saw the baby. That is at 7:00 a.m.
A. Okay.
Q. So we have experienced nurses who are observing this baby and there is no indication of anything amiss until 7:25?
MR. PRICE: Objection. The question is assuming fact as long as she puts it in a question.
THE COURT: Right. You need to restate it as a hypothetical.
MS. KOCZAN: Certainly.
Q. Doctor, I'd like you to assume that Nurse Hendershot has

testified and Nurse Hackney has testified that there was nothing going on 7:00, 5:20 to 7:00, 7:00, nothing going on. I'd like you to assume that as a fact. So based upon those assumptions, can we agree that the very first time anything was noted was at 7:25 a.m.?

A. That's when I first noted something in the record, yes, ma'am.

Q. You said before when you were asked questions that it was at 7:20. Are you aware that that is incorrect, it was actually 7:25?

A. Well, I'm going by memory. I would say five minutes. Okay. I'll grant you if that's what it says.

Q. The reason why I'm asking you that is you made some comment about Dr. Jones being called at 7:20. If there was nothing going on at 7:20 and it didn't happen until 7:25, would you agree that it would make no sense for Dr. Jones to be called at 7:20?

A. Sure.

Q. Now, the testimony of the nurses is that from 5:20 to 7:00, this baby was crying vigorously. Are you aware of that?

A. It wasn't in the records that I saw, but I'm assuming that's what they testified to.

Q. Are you aware that the family also talked about the baby crying?

A. I don't know what the family said, but I'm assuming what

you are stating is correct.
Q. A baby crying is a good thing, correct?
A. Generally speaking, yes.
Q. Now, when Nurse McCrory noted that there was an issue, and do you know what the issue was? Do you remember seeing that?
A. The issue clearly, based on her charting, was respiratory distress.
Q. Are you aware that that is, in fact, not true that the issue that she saw initially was that she thought the baby appeared somewhat dusky? Were you aware of that?
MR. PRICE: Objection, Your Honor.
A. No, but that would make it even more concerning.
Q. And when she saw that the baby was dusky, she immediately got up, she put a pulse oximeter on the baby. Were you aware of that fact?
A. Sure.
Q. And certainly those actions were appropriate, weren't they?
A. Sure.
Q. And it was appropriate for Nurse McCrory to place this baby under the oxy hood?
A. Yes.
Q. And, Doctor, we had heard the term transitioning before. Babies that are transitioning, they can often show signs and symptoms of perhaps respiratory difficulties during the

transition period. Would that be true?
A. Right.
Q. And one of the things that can happen is they can drop their O2 saturation as part of that transitioning?
A. Generally speaking, they don't drop their saturation. They may grunt a little bit or something like that, and they have this thing called transient tachypnea, but generally speaking, they are not hypoxic. They are just tachypnea.
Q. When the oxygen was placed on this baby, her pulse ox came up to 91, correct?
A. Right, from about 81.
Q. I think it was actually 94. I misspoke there. Now, in addition to putting the baby under the oxy hood, checking her pulse ox again, Jamie McCrory also called Dr. Heiple. Were you aware of that?
A. No, I was not aware of that.
Q. You weren't aware --
A. Oh, she called -- I was thinking of Dr. Jones. No. Jamie called Dr. Heiple, yes.
Q. And have you seen her testimony regarding how soon he was there?
A. Yes.
Q. And what did she say about that?
A. He got there around 8:00, well, according to his testimony as well, because he had been attending a lecture.

Q. Doctor, have you seen Jamie's testimony with regard to that?
A. Yes. I think there was a contradiction there that he was there a little earlier than that.
Q. So Jamie thought he came earlier than 8:00, correct?
A. That's what she said.
Q. And in terms of what he did, he immediately assessed this baby, correct?
A. Yes.
Q. And at that point, her oxygen level was increased?
A. Correct.
Q. And he at that point decided to keep therapy going --
A. Yes.
Q. -- what was provided and he was going to wait Dr. Jones coming in because he knew she would be there shortly, correct?
A. That was his decision, yes.
Q. Now, you said something earlier that Dr. Jones didn't get there until 8:15. I think that was your testimony.
A. Correct.
Q. Are you aware that she was actually there around 8:00?
MR. PRICE: Objection, Your Honor.
A. I saw no evidence of that.
MR. PRICE: Objection. This is testimony that hasn't been placed in this record. I don't know where she is testifying from.

MS. KOCZAN: I'm not testifying from anything. There's a record.

Q. Have you seen Dr. Jones --

THE COURT: First off, reference the document and the exhibit number.

MS. KOCZAN: It is the death summary that we have seen before, and it is under Peronis 3 and it's page No. 8 there and I can put the document up. It's 1113, if you would put that up there.

Q. And if we can highlight that first section and look here. This is in the note. "Upon my arrival in the nursery at 8:00 a.m."

Were you aware of that? Had you ever seen this note before?

A. I really don't recall. I probably did see the note, but --

Q. Don't remember seeing it?

A. I remember her saying 8:15.

Q. Excuse me?

A. I remember her saying 8:15.

Q. But you didn't look at this note where she clearly documents at the time this happened that she was there at 8:00 a.m.?

A. She is saying that retrospectively. I don't know which is correct. She is writing this note after the fact and she may

not have been looking at the clock.
Q. Now, Doctor, when she got there, she immediately began arranging transfer of this baby, correct?
A. Right.
Q. Do you know why she wanted to transfer the baby?
A. I don't think they have a level three NICU and she sensed the baby was in danger.
Q. Are you aware that she didn't want to transfer this baby because of the baby's oxygen requirements?
A. That would be another way of saying the same thing, sure.
Q. Doctor, you have talked about your care of infants who have sepsis. You've seen babies with E. coli sepsis; is that correct?
A. I have.
Q. And is it generally the situation with babies with E. coli sepsis that they compensate for a period of time and then, for lack of better word, drop off a cliff?
A. That happens fairly frequently. All babies try to compensate. They want to live.
Q. And they compensate until they've exhausted their reserve?
A. Okay. I would agree with that.
Q. And the blood work that was done in this case that was put up on the screen earlier indicates that this baby had used just about all of her neutrophils to fight infection, correct?
A. Yes.

Q. When the neutrophils are essentially gone, that's when the symptoms developed and she rapidly declined?
A. Not necessarily. Sometimes there are symptoms and then the numbers go down. There's no one-to-one correlation.
Q. In this case, she pretty much exhausted all of her neutrophils?
A. At that time, yes, ma'am.
Q. When she exhausts all the neutrophils, she doesn't have the ability to fight infection, correct?
A. Not entirely, but she has considerably less. Babies are born with other things. Newborns also have an immune incompetence in various areas of their immune system. So unfortunately, they are set up for it, and they also main line their germs, because they inhaled the germs into their lungs and into their bloodstream, so they are at high risk.
Q. Doctor, we don't have any disagreement. You agree this baby died of E. coli sepsis, correct?
A. I do.
Q. You would also agree that the sepsis had been there for some period of time?
A. Bacteremia was there probably first and then the sepsis was there probably second.
Q. So this baby was able to compensate up until 7:25 a.m., correct?
A. Well, I know that's in contention as to whether the baby

was having problems before that. According to the notes, the baby was able to compensate until 7:20 or 7:25.

Q. And you indicated before that a pediatrician, had they been at delivery with a perfectly normal baby at that time, would have just said watch the baby, monitor the baby, correct?

A. That's correct.

Q. And in fact, that's what they did. They watched the baby, they monitored the baby. Jamie McCrory monitored the baby and picked up there was something going on at 7:25 a.m., correct?

MR. PRICE: Objection, Your Honor. Again, she is assuming facts that aren't in evidence.

THE COURT: Right.

A. That's what is documented in the records.

Q. When Dr. Jones got there, you are aware, are you not, that she ordered a variety of things?

A. Yes.

Q. She ordered CBC. She ordered a chest x-ray. She ordered the antibiotics, correct?

A. Yes, and a blood culture and a chest x-ray.

Q. Blood cultures, all that?

A. Capillary blood gases.

Q. Do you know what time the first antibiotic was given?

A. According to my records, the ampicillin was not given until about 9:45, and according to the other records I read,

it was very difficult to find out when the gentamicin was given, I think, because the baby was further decompensating.

Q. Doctor, let me put up the record for the ampicillin. This is in the baby's record and this is in Peronis 3. It's page 228 and it is document No. 1333, and if we can highlight the section where it talks about the ampicillin, which is about midway down the page.

That's the ampicillin that was given, and do you see what the time was on that?

A. So that would say 8:35 basically.

Q. Okay. We can put that down.

So the ampicillin was given. Dr. Jones intubates the baby when she sees respiratory distress, and at that point, that's probably around, what? 9:40 a.m.? Do you recall that being the situation?

A. 9:40 to 9:50.

Q. And the West Penn team arrives at 8:45 -- excuse me -- 9:45.

A. Right. I know there was a five-minute gap between when she intubated and when the West Penn team arrived.

Q. I want to ask you one other thing about your testimony. You made some comment that this wasn't so advanced that something could not have been done because of the platelet count and there was no evidence of bleeding, correct?

A. That would be one indication. There's always something

you can do, but that would be one indication that at least the situation wasn't hopeless.

Q. Doctor, are you aware that during the resuscitation effort, there, in fact, was bleeding?

A. Yes.

Q. She had a pulmonary hemorrhage, didn't she?

A. She did.

Q. When antibiotics are given, particularly for an E. coli infection, is it the situation that the antibiotics cause the E. coli to release toxins?

A. They can, yes. There's endotoxin, and they can release some of that into the bloodstream.

Q. That would make the baby sicker at least initially; would that be true?

A. That's if the antibiotic was directed at the E. coli.

Q. And the medications that were given were directed at the E. coli, correct? That was the reason why they were given?

A. Directed, but the ampicillin would have been totally ineffective.

Q. The gentamicin -- and you said the ampicillin would be totally ineffective why?

A. Because the organism was resistant not just in the blood culture but in the lung culture.

Q. But it was certainly appropriate to give the ampicillin, correct?

A. Sure.
Q. And antibiotics don't work instantly, do they?
A. No, they don't.
Q. They take some time to work?
A. Sure.
Q. Doctor, are you aware that another pediatric infectious disease expert has looked at this case?
A. I'm certain one has. That's usually how the system works.
Q. Have you seen Dr. Susan Coffin's report?
A. No, I have not.
Q. Do you know who Dr. Coffin is?
A. No, I don't.
Q. Would it surprise you if I told you that Dr. Coffin has a very different opinion about this case than you do?
A. Yes. She testified on the other side. That would hardly surprise me.
Q. Would you agree that, during the course of your career, there have been distinguished colleagues who have had different opinions about a case than you?
A. Of course.
Q. And in the -- what did you say -- 500 cases that you reviewed, there was someone on the other side who disagreed with your opinion, correct?
A. The half that I would have given depositions or trial, yes.

MS. KOCZAN: Thank you. That's all I have.

THE COURT: Mr. Price, any additional questions?

MR. PRICE: Just a few.

REDIRECT EXAMINATION

BY MR. PRICE:

Q. Doctor, I know that you were asked a lot about assuming facts. If there is testimony that this baby was crying for an hour and a half in a way that shocked the parents and that they did not feel that it was normal crying and that the baby was in pain, would that be any indication to you that a pediatrician should have been monitoring this baby?

A. Yes.

Q. And does that follow up on what you testified that, after delivery, you believe that a pediatrician should have evaluated this baby?

A. Yes.

Q. And that if there is testimony that the baby was having crying spells, was in pain, those were the types of things that, if a pediatrician were monitoring the baby, would be picked up?

A. Yes. That kind of crying could be called irritability and could indicate sepsis or lung pain. Baby had a small pleural effusion that hurts the baby, makes the baby hurt when breathing. Babies could have meningitis and they could have it this early, and that could cause profound irritability.

Q. I know you were retained in this case to look at the case from an infectious disease point of view, correct?
A. Correct.
Q. And you are not here to talk about whether or not Dr. Dumpe delivered this baby correctly or anything of that nature?
A. Correct.
Q. And I know that you were asked how many depositions you reviewed and all of that. I know that you reviewed some of the information from this Nurse Hackney. She was the one at shift change at 7:00. Do you remember that?
A. I don't remember reviewing that. I remember Nurse McCrory. I don't remember Nurse Hackney.
Q. And I know that the questions you were asked to assume with regard to how Nurse McCrory and Nurse Hackney saw this child, that it was -- the only issue that was brought up was that it had an 81 pulse ox, but in your review of the notes, did you also note that Kendall was grunting, flaring, there were notes she was in pain, gasping for breath, things of that nature?
A. Yes.
Q. Does that all lead to a diagnosis of respiratory distress?
A. Of course.
Q. One final question. I know you talked about the fact that this child died from E. coli, and that is an atom bomb, as you

mentioned, and there was another one with meconium.

If either of those were separated, for example, if she just had an E. coli infection or she just had meconium, in your opinion, would she have had a fighting chance in this case?

A. Sure.

Q. So the fact that she had an E. coli infection, she would have had a fighting chance, but with the meconium on top of that, it decreased? She lost the chance?

A. She lost some chance because of the meconium, yes. I think they would be additive.

MR. PRICE: That's all I have, Your Honor. Thanks.

THE COURT: Mr. Colville, any additional questioning?

MR. COLVILLE: No questions.

THE COURT: Ms. Koczan, any additional questions?

MS. KOCZAN: No questions.

THE COURT: Thank you, Doctor, for your appearance here today. May the doctor be excused?

MR. PRICE: Yes.

THE COURT: Doctor, you may step down. You may also be excused.

(Witness excused.)

THE COURT: Mr. Price?

MR. PRICE: Pursuant to the court's request. I have PowerPoint copies of what I showed Dr. Shore.

THE COURT: That will be another plaintiff demonstrative, Mr. Galovich, for your records.

Now, Mr. Price, are you ready to call your next witness?

MR. PRICE: Yes. We will call Tyler Janectic.

THE COURT: Mr. Janectic, if you'll approach Mr. Galovich to be sworn.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Tyler Janectic, J-A-N-E-C-T-I-C.

THE COURT: Thank you, Mr. Janectic. Watch your step getting up. You may proceed.

MR. PRICE: Thank you.

TYLER JANECTIC, a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PRICE:

Q. Tyler, could you please tell us again your name and where do you live?

A. My name is Tyler Janectic. I live in New Brighton, PA.

Q. And are you related to Matthew Fritzius?

A. Yes. He's my cousin.

Q. Are you friends with him?

A. Yes.

Q. I know some cousins might not be, but do you hang out with

him?
A. Yes.
Q. What about Carissa? Do you know Carissa?
A. Yes.
Q. Can you tell us a little bit about how you guys all got together -- let's talk before Kendall. Would you guys hang out socially? Did you go to school together? What was your relationship?
A. We would hang out. I would go to their house, watch movies, watch sports, just socially.
Q. Were you friends with them while they were dating?
A. Yes.
Q. And did you know that -- how did you find out that Carissa got pregnant?
A. Matthew told me.
Q. And was it happy times? Sad time for them? How did they take the pregnancy?
A. Happy.
Q. Now, did you follow the pregnancy? Were you friends with them while Carissa was pregnant?
A. Yes.
Q. Tell us about that. What do you remember? Anything?
A. What specifically? I guess I don't know.
Q. Sure. I mean, were they -- did they share the pregnancy with people? Were they quiet about it?

A. I believe they were quiet at first and then they told everybody.
Q. Were they, in your -- when you saw them, were they hopeful about the pregnancy or were they concerned?
A. Like most normal people when they have children, they are a little scared, but they were mostly happy.
Q. Now, I'm going to jump ahead to October 12 of 2014, and did you find out that Carissa was in the hospital?
A. Yes.
Q. How did you find out?
A. I received a phone call. I can't remember exactly from who, but it was someone in my family.
Q. And do you remember what was the discussion topic?
A. It was just Carissa is in labor. She is at the hospital. I went right up.
Q. Do you remember about what time you arrived at the hospital?
A. Somewhere between 10:00 and 11:00 p.m.
Q. Do you remember whenever you got there, were there other family members at the hospital?
A. Yes.
Q. Do you remember who?
A. Carissa's sister's Nicolette, her mother, her grandmother, my cousin Kylee and my Aunt Monica.
Q. Were you all in the labor and delivery room with Carissa?

A. No. We were in the waiting room.
Q. Did you have, at any time before Kendall was born, have a chance to go into the labor and delivery room?
A. I don't believe so, no.
Q. Do you know if anybody, like did Matt come out and talk to you at all?
A. Yes.
Q. Did he tell you anything about how the labor process was going?
A. No.
Q. At any point, did any other family members, to your knowledge, go into the labor and delivery room?
A. Not that I'm aware of, but it is possible.
Q. Now, Kendall was born around 5:20 in the morning. Do you remember that?
A. Her being born?
Q. Yes. Do you remember being told?
A. Yes.
Q. Where were you?
A. In the waiting room.
Q. And do you remember who came out?
A. I do not recall.
Q. Do you remember about how long it was after Kendall was born that you were told that she was born?
A. Maybe like 15, 20 minutes or so.

Q. Do you remember seeing any of the doctors or nurses after the delivery?
A. No.
Q. At some point, were you allowed to go into the room?
A. Yes.
Q. And whenever you went in, what did you see?
A. Family just hanging out. I believe Christine was holding the baby whenever I got there.
Q. I'm going to show you some pictures we have and ask you to identify some of the people in the pictures. If you could first pull up Exhibit 36 and can you tell us who is shown in Exhibit 36?
A. That's Matthew and Kendall.
Q. And did you see Matthew holding Kendall at all?
A. When I first got there?
Q. Yes.
A. Not when I first got there, no.
Q. It was Christine that was holding --
A. Yes.
Q. If we could pull up Exhibit 41. Is that Christine? Is that the grandmother?
A. Yes.
Q. Did you see her holding --
A. I'm sorry. I thought Christine was her mother's name.
Q. Dana?

A. Yes, Dana. I'm sorry.
Q. Okay. Then we will pull up Exhibit 42, and Exhibit 42, Dana is on the right?
A. Yes.
Q. And who is that holding the baby?
A. That's Kylee.
Q. Do you know who Kylee is?
A. She is Matthew's sister.
Q. Okay. Whenever you went in, do you remember was Kylee in the room?
A. Yes.
Q. And was she holding the baby?
A. Yes.
Q. Now, did you at any time get to hold Kendall?
A. I was too scared to so I didn't.
Q. I guess, do you have any children of your own?
A. No.
Q. Okay. Was this the first baby of a friend of yours that you had seen?
A. Yes.
Q. Now, tell us a little bit about -- so you come in and you see Kendall being held by some family members. What was your observations of Kendall?
A. She was just crying.
Q. Now, I know that babies cry. We've heard that in this

case, but can you describe for us, whenever you heard her crying, how would you describe the crying?

A. I would describe it as more of a wailing, like it didn't sound pleasant. I've heard babies cry before but not like that.

Q. Did you talk to anybody about that?

A. Matthew was concerned and he asked me to go get the nurse.

Q. Whenever this came up, how did Matthew bring up to you the fact that he was concerned?

A. Just I'm really concerned, like she is crying really bad. She hasn't stopped. Can you please go get a nurse? I went to grab her. She poked her head in the room. Just said that's normal. That's fine. Just spend time with her.

Q. So just let me back up and get a little bit more of the details. So you are in the room and Matthew asks you to go find a nurse?

A. Yes.

Q. Then did you go out into the hallway or did you --

A. Yes, into the hallway.

Q. Do you remember how far you had to go to find a nurse?

A. Not far.

Q. Do you have any recollection of what the nurse looked like?

A. I do not.

Q. I will -- if you could pull up Exhibit 17. This is

Nurse Hendershot. Does she look familiar to you?
A. Vaguely.
Q. Do you know if this was the nurse who you went out to talk to?
A. I can't say 100 percent certainty.
Q. So whenever -- can you put the other picture back up? Whenever -- this nurse that you talked to, what did you say to her?
A. I just said my cousin feels like there's something wrong with the baby. She is crying. Can you come check on her?
Q. What did she say in response?
A. She got up. She came in. She didn't actually come in the room. She kind of like poked her head in, listened, heard the baby cry and said that's normal, just spend time with her.
Q. Did you see the nurse come in and hold the baby or touch the baby?
A. No.
Q. Could you tell us about how far away was the door to where the baby was?
A. I would say from me to you maybe.
Q. Do you remember whether or not -- let me back up.
How long were you in the room with Matt, Carissa and the baby?
A. About 30 minutes or so.
Q. And if 5:30 was around the time that they started coming

in until 7:00, do you remember what time frame that 30 minutes was? Was it closer to 7:00? Was it closer to 5:30?

A. Somewhere between 6:15 and 6:30ish. I believe I got home around 7:00.

Q. During the time that you were in there, do you remember any nurse coming into the room?

A. No.

Q. Do you remember any nurse coming in and examining Carissa?

A. No.

Q. Do you remember any nurse putting their hands on Carissa and checking her belly or anything of that nature?

A. No.

Q. Did you see any doctor come into the room while you were there?

A. No, I did not.

Q. Besides that one time that you went out to get a nurse, do you remember, did anybody else try to go out and get a nurse?

A. Not to my knowledge, no.

Q. Whenever that happened and the nurse said what she said, what was the conversation between you and Matthew?

A. We just kind of accepted it for what it was.

Q. Did Matthew say anything further?

A. Not to me, no.

Q. Do you remember was Carissa saying anything during this time?

A. She was kind of in and out of it. She wasn't really there when I was in the room.
Q. She was sort of sleeping, tired?
A. Yeah.
Q. Did you see Matt take Kendall to the nursery?
A. I left just before that.
Q. Was there anybody else in the room whenever you left besides Matthew and Carissa and Kendall?
A. Taylor Moore and I believe Kylee was there, too.
Q. After you left the hospital, you went home, correct?
A. Correct.
Q. What was the next thing you were told?
A. I fell asleep. I woke up to a phone call from his sister Kylee, and she said we need to get to the hospital. There's something wrong.
Q. What did you do?
A. I got up, went and picked her up and we went to the hospital.
Q. Were you present whenever the doctors and nurses came in to tell you about what happened to Kendall?
A. No.
Q. Did you have a chance to talk to Carissa and Matt after that?
A. Very, very briefly.
Q. How were they?

A. Not well.
Q. I know that you have had a chance to see them after this. Did you have a chance to talk to Matt about Kendall's passing?
A. A little bit, yes.
Q. How is he doing?
A. Not well.
Q. Can you tell us why? Can you describe for us what you mean by that?
A. I have grown up with Matt. I've watched him my whole life. He's been very outgoing, a very caring person, and this whole thing has just devastated him. He's not the same. He's closed off. He's distant. He's just not himself.
Q. What about Carissa? Have you seen her since?
A. Little bit, yes.
Q. Have you had a chance to talk to her about how this --
A. Not a whole lot, no.

MR. PRICE: That's all the questions I have, Your Honor.

THE COURT: Cross-examination, Mr. Colville.

CROSS-EXAMINATION

BY MR. COLVILLE:

Q. Morning, Mr. Janectic. My name is Mike Colville. I represent the United States in this case. Just a few follow-up questions.

So you arrived at the delivery room around 6:15; is that

right?
A. Somewhere between there and 6:30.
Q. So it was about an hour after the baby was delivered in this case?
A. Yes.
Q. Was this the first time you had been to a delivery suite?
A. Yes.
Q. First time you have been to a hospital to see a newborn baby?
A. Yes.
Q. Do you have any children yourself?
A. I do not, no.
Q. Have you ever heard what a baby sounds like an hour after it's been born?
A. No.
Q. So this was the first time?
A. Yes.
Q. Were you nervous?
A. No.
Q. Can we put Exhibit 42 up? When you arrived, who all was in the room, if you remember?
A. When I got there -- you mean who came with me in the room?
Q. When you get to the delivery room, who was in the room and who was with you?
A. Matthew, Carissa, Dana, Kylee and I went in with Taylor

Moore.

Q. What was happening?

A. We were just -- everybody was hanging out holding Kendall.

Q. Were they passing the baby around?

A. Yes.

Q. Were they still taking pictures?

A. I don't recall.

Q. This picture here, this Exhibit 42, on the right, who is that? That's Dana?

A. Dana, yes.

Q. Who is holding the baby?

A. That is Kylee.

Q. Now, during the hour that you were present from -- 6:15 to 6:30, did you observe any pictures being taken?

A. No.

Q. Did you observe people holding the baby like in this picture?

A. Yes.

Q. Were they smiling like they are in this picture?

A. Yes.

Q. When Matthew -- if you are only there 15 minutes, how soon after you arrived did Matthew come to you and say can you go out and get a nurse?

MR. PRICE: Objection. He testified he was there for at least a half hour.

MR. COLVILLE: I'm sorry. I wrote 6:15 to 6:30.

Q. You arrived between 6:15 and 6:30?

THE COURT: Correct. That's when he arrived.

Q. For the half hour you were there, after arriving at 6:15 or 6:30, how soon after you arrived did Matthew come to you and say please see a nurse?

A. About 20 minutes in.

Q. The people in the room were still holding the baby and passing it around?

A. Yes.

Q. They were still smiling?

A. Yes.

Q. And the specific -- not complaint, but what Matthew had come to you to go relay to the nurse was about the crying?

A. Yes.

Q. He didn't tell you to please go tell the nurse that the baby is grunting; is that right?

A. No.

Q. Now, you mentioned that the sound you heard the baby make was different than crying. It was wailing, right?

A. Yes.

Q. We've established you've never heard what a newborn baby sounds like, right?

A. Not at the present time, no.

Q. But the nurse who you went and reached out to who came in

told you that the crying she heard was normal?
A. Correct.
Q. Now, you were asked about whether or not nurses came in and out of the room while you were there for that half hour. You said you don't remember. I want to clarify.
Are you saying you don't remember it happening or you are saying it didn't happen?
A. I'm saying no, it didn't happen.
Q. So no nurse, at least for the half hour you were there?
A. At least for the half hour I was there, yes.
Q. There's no doubt in your mind that you were in the room for more than 15 minutes at any given time?
Let me ask you this: Were you in the room for the whole half hour?
A. Yes.
Q. Did not leave?
A. I did not leave.
MR. COLVILLE: Thank you.
THE COURT: Ms. Koczan, cross-examination?
MS. KOCZAN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MS. KOCZAN:
Q. Tyler, is the situation that what you observed when you were in the room was simply Kendall crying or, as you put it, wailing?

A. Yes.
Q. And when Matt asked you to go get the nurse, the reason he asked you to get the nurse because of crying, correct?
A. Yes.
MS. KOCZAN: That's all I have. Thank you. I do have one more.
Q. You said that the nurse was standing the distance from you and Mr. Price?
A. I would say maybe a little bit further back, yes.
Q. Further back than that. Do you know how large those labor and delivery rooms are? Do you know the dimensions of the room?
A. I have no idea.
MS. KOCZAN: Thank you. That's all.
THE COURT: Mr. Price, any other questions for this witness?
MR. PRICE: No, Your Honor.
THE COURT: The court just has one or two questions.
Could you just tell us a little bit about your educational background and where you currently work, sir?
THE WITNESS: I work in the Super 8 in Beaver Falls and I graduated from high school. It's my highest level of education.
THE COURT: Thank you. I understand you have to get to work this afternoon, right?

THE WITNESS: Yes.

THE COURT: Any other questions of this witness? May he step down and be excused?

MR. PRICE: Yes.

THE COURT: Thank you, Mr. Janectic, for your appearance here today. Watch your step getting down.

(Witness excused.)

THE COURT: Mr. Price, would you like to start with another witness?

MR. PRICE: Yes. At this point, Nurse Jamie McCrory.

THE COURT: Nurse McCrory is going to come in.

MS. KOCZAN: Should I go get her?

THE COURT: Yes, I think so. She is being called.

THE CLERK: Please step forward, miss. Please state and spell your name for the record.

THE WITNESS: Jamie McCrory, J-A-M-I-E, M-c-C-R-O-R-Y.

(Witness sworn.)

THE COURT: Nurse McCrory, watch your step as you get up. It's a little uneven. You may proceed.

MR. PRICE: Thank you, Your Honor.

JAMIE MCCRORY, a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PRICE:

Q. Nurse McCrory, first, could you tell us your full name and where you work?
A. My name is Jamie McCrory. I work at Heritage Valley Beaver Hospital. I am a labor and delivery, maternity and nursery nurse or maternal child health nurse.
Q. If you could move up or put that a little bit closer so the jury can hear you. Thanks.
So you work as a nursery nurse and labor and delivery nurse?
A. Yes.
Q. And obviously you went to school for that?
A. Yes.
Q. Where did you go to school?
A. I went to Heritage Valley Health Systems Sewickley School of Nursing and I graduated with my nursing degree from Sewickley Valley Hospital, Heritage Valley Health System School of Nursing, and then I went on for my bachelor's in nursing from Penn State.
Q. You have been working at Heritage Valley Beaver for how long?
A. I've been working at Heritage Valley Health System since 2009, and I've been working as a registered nurse since 2011.
Q. And do you continue to work at Heritage Valley Beaver until today?
A. Yes, I do.

Q. And do you still work in the labor and delivery and the nursery?
A. Yes, that is correct, I do.
Q. And from what I understand, you come into work every day, and depending upon how the staffing is, you could be assigned to labor and delivery or nursery?
A. Yes.
Q. It just happened to be that on October 13, 2014, you were assigned to the nursery?
A. That is correct, yes.
Q. And your shift started around 7:00 that morning?
A. 7:00 a.m., yes.
Q. And whenever you come on to a shift as is normal, you get a report from the nurse who was coming off shift?
A. Yes.
Q. And that nurse who was coming off shift was Barb Hackney?
A. Yes.
Q. She would give you a rundown on all of the babies who were in the unit?
A. Yes.
Q. And what she told you was that it was a busy morning, there were about eight to ten babies who were on the unit, correct?
A. I do not recall the number of babies that were on the unit that day, no, I do not.

Q. You remember it being a busy day?
A. It was a busy day, yes.
Q. And I know that we have this issue with Kendall, and that at 7:25, things started happening, and we're going to talk about that, but from what I understand, there was also another baby in the nursery who had some serious conditions?
A. Yes.
Q. And, of course, I don't want to get too deep into that baby's history, but can you describe for us how serious of a condition that baby was in?
A. The other case or the other baby's condition was more of a physical condition that doctor had to assess as well as all the other babies they assess in the day, so it was a serious condition that I do not recall the specifics, but it also required a transfer that day to a Pittsburgh hospital.
Q. And that baby was going to be LifeFlighted to Children's Hospital?
A. That is correct, yes.
Q. And ultimately, Kendall was planned to be LifeFlighted to West Penn Hospital?
A. Yes, that is correct.
Q. Now, you were the only nurse assigned to the nursery that morning, correct?
A. Yes, that is correct.
Q. And from what you remember, whenever you were getting

report from Nurse Hackney, that the father of the baby came into the nursery with Kendall?

A. The father of the baby was already in the nursery at the infant warmer or the radiant warmer. He was already in the nursery at the warming station.

Q. Okay. Now, just to give the jury a little understanding, when a baby comes into the nursery, they are to get a full assessment, correct?

A. That is correct, yes.

Q. Now, the only thing was that when Barb was -- she checked the baby in, she was going off shift, so she asked you to do the complete assessment on Kendall, correct?

A. Yes.

Q. She might have taken a set of vitals and put some eye drops in and given a shot, but she didn't assess the baby, correct?

A. She did not chart a baby assessment.

Q. That was what you did and your notes reflect that it happened at 7:25?

A. Yes.

Q. I know your notes reflect that it happened at 7:25, but could it have happened a few minutes earlier at 7:20?

A. There's always marginal room for error, yes. It could have happened give or take five or ten minutes before.

Q. That 7:20, 7:25, I know, is an issue in this case, but it

was around 7:20, 7:25 when you were doing your assessment and getting ready to see how Kendall was?
A. Yes.
Q. Now, whenever you are given report by Barb, you noticed that when you were told about Kendall, she looked a little dusky to you?
A. Yes.
Q. Can you describe for the jury, to a nurse, what does "dusky" mean?
A. Dusky means a little pale in color, not your normal warm, pink, not the normal color we see on the majority of the babies that we assess in the nursery.
Q. And that to you, I mean, it perked up your ears as a nurse and you were concerned at that point, correct?
A. Yes.
Q. And at that point, what you did was you did a pulse ox. Is that what it's called?
A. Yes.
Q. Can you explain to the jury how you did that for Kendall?
A. I put a pulse ox on the hand or the foot, and pulse ox is just measuring the oxygen-carrying capacity. Typically, we like to put it on the right hand, and her pulse ox was reading in the 80s at that time.
Q. Now, I'm going to show you some of the documents. I know you've seen these, but I just want the jury to understand what

you were doing. If we can start on tab 6, page 60, and we start here at 7:25.

So these are your first notes with regard to Kendall and her respiratory rate, correct?

A. Yes.

Q. Now, again, just to step back for a moment. When this happened along with the other baby you had and along with what all happened with Kendall and her resuscitation, calling for LifeFlight, it was a very busy morning for you?

A. It was a very busy day in the nursery, yes.

Q. And sometimes whenever you are working as a nurse, obviously your first concern is to take care of the patient?

A. Yes.

Q. And you have some notepads where you might be able to jot down things about the baby or some vitals or things of that nature, right?

A. Yes.

Q. And it isn't until everything is done, everything is -- I don't want to say calmed down, but at some point when you get a break where you might chart?

A. Yes.

Q. So while we see the vital signs and this stuff being done at 7:25 a.m., it may have been a few minutes earlier; it may have been a few minutes later, correct?

A. Yes.

Q. And in fact, these notes that you made, it wasn't until almost 12 hours later at 19:56 that you actually put this into the computer, correct?
A. Yes.
Q. So you have a busy day and you have some notes with you and you are finishing your shift and you have to complete your paperwork, so if there's some discrepancy in the time, it might be because it's been 12 hours?
A. And it's an emotionally draining day and because it was 12 hours, yes.
Q. And if we are off by a minute or two, you are not trying to -- you are just trying to do your charting and trying to recreate from your notes as best as you could what time things happened?
A. Yes.
Q. So but you'll agree that this all happened around 7:20, 7:25 in the morning?
A. Yes.
Q. Soon after your shift started?
A. Yes.
Q. Now, if we could go to the next page, page 62 of tab 6. This is continued vital signs right here. This is where you are taking a look at Kendall and you note that she is grunting, flaring and retracting, correct?
A. Yes.

Q. And I know we've heard the GFR and if you hear the term "GFR," it's grunting, flaring and retracting. You also note that she appears to be in pain, correct?
A. Yes.
Q. And then if we could go to page 65, and again, I know these are electronic medical charts and we are jumping around a little bit but if we could pull that out and here you have nasal flaring, grunting and then you have substernal retractions.
Can you describe for the jury what that means?
A. When a baby is working hard to breathe, they use different muscles a normal breathing person would not be using whenever they are working hard to breathe. They are deeper breaths and it's just -- it's just an indicator that something is wrong respiratorily.
Q. And you also noted that her breathing was labored and she was using her abdominal muscles to breathe; is that correct?
A. Yes.
Q. Now, I know that this might be difficult, but could you, I guess, sort of demonstrate for the jury the difference between normal breathing and breathing which is nasal flaring, grunting, have substernal retractions, abdominal muscle use. What do you see and how is that different from normal breathing?
A. It would be the equivalent of you breathing normal versus

choking on something, gasping for air, things of that nature. I would say that difference in breath of somebody just normally gradually breathing versus a baby that is struggling to breathe.

Q. From what I -- is this the type of thing where a baby is going like this (indicating) and you can see it, not feel it, but you can see a baby struggling to breathe?

A. Yes.

Q. That's what you saw?

A. Not at 7:25, but because of my charting, things got generalized, and the work of the way that things were -- the way that the workup went with the baby and the way that my charting at the end of the day, it was more of a generalized -- it was more of a general description as to how things progressed because she was not and I can't take back what I charted, she was not grunting, flaring and retracting when I put the pulse ox on the baby, so the timeline is tough.

Q. I understand that, and I understand that some of your charting was done 12 hours later.

A. Yes.

Q. But you'll agree with me that with regard to all of the nasal flaring, grunting, substernal retractions, labored breathing, you put into the time frame the time slot of 7:25 in the morning, correct?

A. Yes, and it was a very distressful time for me, as was for

most people that worked that day, yes.
Q. I understand. And to a certain extent we are trying to recreate what happened that morning, but you could have chosen to put simply the oxygen level at 7:25, grunting, flaring and retracting at 7:35, something at 7:45, if you wanted to, correct?
A. Yes, I could have.
Q. So all of these notes that you put in were put in for the 7:25 time slot?
A. That is correct, yes.
Q. And then also we note here the nailbeds, they were dusky, correct?
A. Yes.
Q. And I'm sorry. There's something else on this, if you could back out of that. Is that page 65? Maybe it's page 67. There it is. Right there.
Here, we have breath sounds were coarse, both anterior and posterior. So I assume that means that you are listening with a stethoscope?
A. Yes.
Q. And you listened to the front and the back, and whenever you did that, you could hear coarseness in the lungs?
A. Yes.
Q. If we could continue down on that page. It might be the next page. Sorry. Keep going. Maybe at the top of page 67.

At some point then, you contacted the resident, correct?
A. Yes.
Q. Now, from your recollection, whenever this assessment was all going by, Matt was still in the room in the nursery watching?
A. Yes.
Q. And whenever you said that you remembered that at some point Matt was there whenever the resident came down and talked to him?
A. Yes.
Q. And you also remember that Matt was there whenever Dr. Jones made the orders for the CBC, blood cultures, chest x-rays, things like that?
A. Yes.
Q. Now, if we go to tab 6, page 30. So this top part here, this is another medical record which talks a little bit about just the practices at Heritage Valley Beaver. This is a note by your supervisor, correct?
A. Supervisor at the time, yes.
Q. So whenever you put a baby in an oxy hood, that is an abnormal -- that's a level of care that you have to make sure that supervisors know about, correct?
A. Yes, typically.
Q. So your supervisor, you notified. It says manager supervisor notified at 7:20 in the morning, correct?

A. This is not my documentation.
Q. I know. I know. That's what I'm asking you.
This document says that manager supervisor Peg Brooks was notified at 7:20, correct?
A. That's somebody else's charting though.
Q. I know. I'm asking you if that's what this document says?
A. It says that, yes.
Q. It also says that Janet Kincade was notified at 7:20, correct?
A. Janet Kincade is the supervisor.
Q. That's the point about all this is that if you put a baby in an oxy hood, you have to alert a supervisor?
A. I act first and then call later.
Q. Right. Yeah. You put the baby in the oxy hood and you alert your supervisor, this baby is in an oxy hood, it needs oxygen. I need more help here, correct?
A. Yes.
Q. That was the whole purpose, because once you know that a baby is going into an oxy hood, the level of care has just jumped up, correct?
A. It depends.
Q. Well, what it depends upon is the level of oxygen you are giving to the baby, correct?
A. Potentially, yes.
Q. And that's why there's policies that if you have to give a

certain amount of oxygen to a baby, you better alert pediatricians, doctors and supervisors?

A. Doctors primarily and then supervisors.

Q. Right. And the doctor that you notified was doctor --

A. Dr. Heiple, resident.

Q. Right. There is a note here on tab 6, page 30 that Dr. Jones was also notified at 7:20. You see that?

A. I do see that.

Q. Do you have any recollection of talking to your supervisors about what was happening in the nursery on the morning of October 13?

A. I know that they were informed that I needed some assistance in the nursery. I notified the resident that I would need some assistance.

Q. Did you have a chance to talk to your supervisors about what was going on in the nursery that morning?

A. Yes.

Q. During any of your conversations with your supervisors, did they tell you that they had talked with Dr. Jones about the case?

A. The supervisors?

Q. Yes.

A. No.

Q. Do you know whether or not Dr. Jones was contacted by the supervisors at 7:20 in the morning?

A. No.
Q. You don't know that?
A. I know they weren't. I know they didn't contact Dr. Jones at 7:20 in the morning.
Q. That's based upon Dr. Jones' testimony?
A. That's based upon my experience of the day.
Q. We're going to talk about that, but what I'm asking you is specifically you have no knowledge as to whether or not your supervisor has contacted Dr. Jones at 7:20?
A. Directly via phone, no, I do not.
MR. PRICE: Your Honor?
THE COURT: Is this a good time to take a break, Mr. Price?
MR. PRICE: Yes.
THE COURT: As you can see, ladies and gentlemen of the jury, it's just about five to 12:00 so we are going to take our lunch break.
Let me remind you of the instructions that I give you at every recess. Once again, you are not to discuss this case with anyone, including fellow jurors, anybody who might be involved in the trial, seated here in the courtroom, any of the parties, witnesses, anyone else who seems to be affiliated with this case, either when you are coming or going.
Once again, you are not to look for any kind of news coverage, if there is any, about this case, nor are you to do

any independent research either through the Internet or by calling somebody asking questions and the like. You are only to consider what you hear in this courtroom, what you see in this courtroom and then ultimately my final instructions to you.

So once again, you are going to keep open minds, leave behind your binders and notebooks. Mr. Galovich will escort you out. I have a meeting over the lunch hour with people from probation, so I expect we'll get started again here at 1:15 again with Nurse McCrory.

If everyone would please stand.

(Jury excused.)

THE COURT: Nurse McCrory, you may step down. Certainly you may go get some lunch. You've taken the oath. It would not be appropriate for you to discuss your testimony with anybody here, understood?

THE WITNESS: Yes, Your Honor.

(Luncheon recess taken 11:59 a.m.-1:19 p.m.)

(Jury present.)

THE COURT: Thank you, ladies and gentlemen of the jury. I trust you had a nice lunch. The weather has broken and hopefully you got out a little bit. As you can see, Ms. McCrory has already resumed the stand. Let's continue examination, Mr. Price.

BY MR. PRICE:

Q. Nurse McCrory, we had taken a break when we were talking about 7:25 in the morning when you were calling the resident.
A. Yes.
Q. And from what I recollect, although 7:25 is when the pulse ox was low and your notes are about the baby being in pain, grunting, flaring. It would have taken you a few minutes to determine things and then to contact the resident, correct?
A. Yes.
Q. Okay. So if you could pull up tab 6, page 47, and -- I'm sorry, not tab 6, page 47. Tab 6 page 67, and this part down here, and pull it down.
Here is your note residents contacted. What does RT mean?
A. Related to.
Q. I'm sorry?
A. Related to.
Q. Related to infant's dusky appearance and GFR, which is the grunting, flaring and retracting.
A. Yes.
Q. Pulse ox and oxy hood in place, correct?
A. Yes.
Q. If you take that down for a second. Just so we all see, that's at 7:25 in the morning. That's still at the 7:25 in the morning assessment time, correct?
A. Yes.
Q. Now, I want to talk a little bit about you were putting

this oxy hood on Kendall. Now obviously, before you put an oxy hood or oxygen on a patient, you have to make sure that the patient's airway is clear, correct?

A. Yes.

Q. And you did that with Kendall, correct?

A. Yes.

Q. And whenever you did that with Kendall, the first thing you have to do is look in the back of the throat and down to make sure that the pathway -- airway is clear, correct?

A. Yes.

Q. And whenever you, at 7:25, 7:30 were looking down Kendall's throat, you noticed that there was meconium staining on the back of her tongue, correct?

A. Yes.

Q. It wasn't on the front of her tongue, it was on the back of her tongue, back in the back of her throat, correct?

A. Yes.

Q. And after seeing that, obviously you were concerned that now we are two hours after birth and she has meconium staining, so you want to make sure that the airway is clear, correct?

A. Yes.

Q. And part of what you then have to do is suction, correct?

A. Yes.

Q. Because you want to make sure there's nothing obstructing

it, right?
A. Yes.
Q. And you did suction, correct?
A. Yes.
Q. And whenever you suctioned, as you said, you got a lot of junk out, correct?
A. Yes.
Q. Now, if you could pull up the Gatorade picture, and this is a picture of just some Gatorade bottle. I know this is a very bad picture. Hopefully, it's better on the little monitors, but as you can see, on the right-hand side is a clear bottle, the next one is lime green, the next one is a little bit darker green, the final one is almost like a vegetable juice.

So the junk that you got out, was it darker or lighter?
A. I would say none of the above. It's its own consistency. It's hard to explain. It's a darker substance than the blue clear one or the clear clear one.
Q. On the scale going from right to left, you are putting it more closer to the one on the left?
A. Yes.
Q. You can take that down. You did some deep suctioning and you showed in the tube that there was some meconium in there and you told Dr. Heiple, "I got a lot of junk out," correct?
A. Yes.

Q. Now, you then had the oxy hood on -- let me take a break.

Dr. Heiple was not there whenever you put the oxy hood on, correct?

A. Correct.

Q. He came in sometime later?

A. Yes.

Q. But you still had the suction tube with the meconium in it and you still had it there so that you could show it to Dr. Heiple, correct?

A. Yes.

Q. So he saw the amount of meconium in the tube which you were concerned about and called a lot of junk?

A. Yes.

Q. Now, after that -- you believe that Dr. Heiple came down within about five or ten minutes from your call, correct?

A. Yes.

Q. And that would place it to be at about 7:40, 7:45 at the latest?

A. 7:35, 7:40, yeah, something of that nature. Within ten minutes of my phone call placement, yes.

Q. Now, obviously, we're going to have Dr. Heiple testify in a little bit, but he disputes that. You know that?

A. I do not know.

Q. He says that it wasn't until 8:00 that you called?

A. It's been five years since this case, so it's very hard to

remember specifics, but I know that I placed a phone call to the resident immediately after I got baby stable on the warmer bed. Priority is patient.

Q. Okay. I know it's been some years, but it was a few years back that we took all of your depositions and asked you about this, correct?

A. Yes.

Q. And you dispute Dr. Heiple's testimony that it wasn't until 8:00 that you called, correct?

A. The timeline is very difficult for me to remember or recall.

Q. Nevertheless, it wasn't until sometime after 8:00 that Dr. Jones arrived, correct?

A. Yes.

Q. And whenever you remember Dr. Jones coming in, it wasn't a -- how do I want to put it? She was ticked?

A. Yes.

Q. And I'm going to play the clip from your deposition where you describe when she comes in just so the jury can see how you described her coming into the nursery that morning. Okay?

A. Yes.

MR. PRICE: If you could play the clip.

MS. KOCZAN: Your Honor, I'm not sure what the purpose of that is. He can ask her questions about that. I'm not sure why we have to show.

THE COURT: Certainly, you can ask questions about it.

MR. PRICE: I just want to ask her if this is her reaction because her reaction might be different and seems to be different today.

THE COURT: I'll let it go.

(Video playing.)

BY MR. PRICE:

Q. So Dr. Jones was upset about not knowing about this baby earlier?

A. Yes.

Q. Now, again, as to when she comes in to the nursery, I know there's a record that says that she came in at 8:00, but do you have any notation as to when she came in to the nursery?

A. I have notation of when the IV was started on the baby at 8:20 a.m.

Q. And that would take an order from a doctor?

A. That would take an order from a resident or a doctor, yes.

Q. And if you could pull up that tab 6, page 47, and these are the -- if we could -- this part down here (indicating).

These would be the orders that would be given for the medication and the chest x-rays and the ampicillin and blood gas, correct?

A. Yes.

Q. It was requested by the resident, Bradley Heiple, correct?

A. Yes.
Q. And he didn't time that until 8:32 in the morning, correct?
A. Yes. A lot of times, we act first and orders get placed after.
Q. Okay.
A. Or we ask a resident, while we are collecting samples, we ask a resident to put the orders in for us so we can label and send it to the lab as soon as we can.
Q. Sure. And that was at least an hour and five minutes after you first noted that the blood oxygen level was 81 percent, correct?
A. Yes.
MR. PRICE: That's all the questions I have, Your Honor.
THE COURT: Thank you, Mr. Price.
Mr. Colville?

CROSS-EXAMINATION

BY MR. COLVILLE:
Q. Just a couple quick questions. With regard to the suctioning that you did, you mentioned that you pulled up a lot of junk. Is that exactly what you told Dr. Heiple?
A. That was my deposition. I discussed with Dr. Heiple that I pulled out -- that I deep suctioned, and there was a lot of -- there was meconium in the suction catheter.

Q. Could some of the substances also have been mucus and secretions?
A. Yes. Multiple times, there are mucus secretions, meconium. There can be multiple different things that come out.
Q. Could it also have been blood from the pulmonary hemorrhage we know occurred?
A. I don't know. I don't know the consistency of what was in there. I'm sorry.
MR. PRICE: I would just like to object in the sense that the pulmonary hemorrhage wasn't diagnosed for several more hours, and he was assuming that was happening at 7:30 in the morning.
THE COURT: Why don't we pose it as a hypothetical?
Q. Hypothetically, would that account for it?
A. It could have, yes.
Q. Would mucus and secretions also make the substance darker?
A. Yes.
MR. COLVILLE: Thank you.
THE COURT: Ms. Koczan?

CROSS-EXAMINATION

BY MS. KOCZAN:
Q. Good afternoon.
A. Good afternoon.
Q. I would like to go back to the time you came on shift that

day, which I understand was around 7:00, 7:05. Would that be correct?

A. Yes.

Q. When you came on shift, did you receive report from Barb Hackney?

A. Yes.

Q. And I think you've already told us that you don't recall the number of babies that had been born that night?

A. Not specific number of babies that were in the nursery.

Q. You would have, however many there were, received report on all of those babies; is that correct?

A. Every single baby, but also each baby had a nurse assigned to it on maternity because they are coupling. Mom and baby are given a nurse on maternity floor 2, but in the event when a pediatrician is on their way in, all the babies come to the nursery for assessment.

Q. And at the time that you got there, was it the situation that there were only two babies in the nursery, Kendall and that other baby?

A. There may have been, because I do not recall a few other babies in the nursery, but Kendall was one on the warmer bed on the left side in the nursery.

Q. We've heard about this other baby, and I don't want to go into any detail about what was wrong with the baby, but was that baby stable at that time?

A. Stable, yes, but needed transferred.
Q. Right. But there wasn't any active treatment being provided at that time for that baby that you had to provide?
A. A second nurse, that would have been the maternity nurse, had brought the baby back to the nursery, and so there was other nurses on at the time assessing the baby, and there's a lot going on during change of shift in the morning especially when pediatricians are on their way into the hospital for assessment.
Q. And in terms of pediatricians on their way into the hospital, you worked in the nursery before; is that correct?
A. Yes.
Q. And you were familiar with Dr. Jones?
A. Yes.
Q. And were you familiar with her routine?
A. Yes.
Q. And was it her routine to be there generally at 8:00 every day?
A. Dr. Jones is a very punctual person.
Q. And she was there at 8:00 every day?
A. For the most part, or sometimes earlier. She is definitely one that is very punctual.
Q. When you got report from Barb Hackney, do you have any recollection of Barb indicating to you that there had been any issue with Kendall up to that point?

A. No.
Q. And did Barb tell you or were you aware that Barb had done vital signs on Kendall already?
A. She had informed me that she did a set of vital signs on the baby and that she gave the baby a vitamin K shot and erythromycin eye drops in the eyes. It's a standard procedure we give to all babies unless parents refuse it.
Q. When she gave you report on Kendall, did she also give you a history? By that I mean, did she tell you the time she was born?
A. Yes.
Q. Did she give you any information about what had happened in the delivery room?
A. Background, we have a sheet, a delivery note sheet we used to use because everything is evolving and ever changing, so I apologize in regard of charting aspects because there's so many things that we don't do now that we did then, but there was a paper chart that we used that showed the Apgars, the weight, the time of delivery, any complications that may have arose from report from the labor and delivery nurse and then passed to the nursery nurse.
Q. Do you have any recollection -- let me just stop there for a second.
Were you aware that there was meconium-stained fluid noted at the time of delivery?

A. Yes. There was notation that there was meconium, thin meconium present, and I mean, there's multiple different things that we record and places that we record them on.
Q. Do you have any recollection of hearing in the report from Barb Hackney that there had been any issues with Kendall up to that point?
A. No.
Q. So Barb begins to give you report on all of these nursery patients, and as I understand it, you correct me if I am wrong, that as you are getting report, you are actually in the nursery; is that correct?
A. Yes.
Q. And you can visualize the babies that are in the nursery?
A. Yes.
Q. Is it the situation that while you were getting report, you looked up and you noticed what you've already described with regard to Kendall looking dusky?
A. Yes. She had a weird color to her. She didn't look right to me. So my instinct -- my nursing instinct was just to check her out.
Q. Okay. When you looked up and you noted that, was there any discussion between you and Barb?
A. Yes. Barb asked me if I needed any help because I did the pulse ox. I said she looks dusky to me. Let me put a pulse ox on. She didn't seem too concerned and when we saw the

pulse ox was low, she said, well, let me help you -- it takes a few, you know, movements to get things that you need for oxygen for -- to put an oxy hood on.

Q. Do you remember there being any discussion with Barb about whether that had been present -- "that" being the duskiness -- present before that moment in time?

A. No. She had said -- it was just concerning to her that the pulse ox was low.

Q. And after you noticed that, you got up and you put the pulse ox on, correct?

A. Yes.

Q. And after you put the pulse ox on, that is when you notified what, your supervisor?

A. Supervisor, yes.

Q. I want to ask you some questions about that. We've seen this note from the supervisor. This is Janet Kincade.

A. Uh-huh.

Q. Before we talk about the note, let me ask you this: Did you call Dr. Jones that morning?

A. No.

Q. Did you see Janet Kincade calling Dr. Jones that morning?

A. No.

Q. Did Janet Kincade ever tell you that she called Dr. Jones that morning?

A. No.

Q. Did Barb Hackney ever tell you that she called Dr. Jones that morning?
A. No.
Q. Did you observe Barb Hackney calling Dr. Jones that morning?
A. No.
Q. And when you called Dr. Heiple, I think you've told us, you did that why? Why him?
A. Chain of command. You contact the resident on to come lay eyes on the baby to assess the baby and to inform the supervisors so they know what's going on.
Q. So your protocol was not to call Dr. Jones but to call Dr. Heiple and what's what you did?
A. Yes.
Q. I want to ask you some questions about the call to Dr. Heiple. You were asked questions about what time it was. You've documented there at 7:25?
A. Yes.
Q. And you've told us it could be 7:25. It could have been a couple minutes before or a couple minutes after; is that correct?
A. Yes.
Q. You don't think it would be any later than that; would that be accurate?
A. Typically no, no.

Q. In terms of Dr. Heiple's response, do you have any recollection of how long it took from the time you called him until he showed up in the nursery?
A. I would say approximately ten minutes.
Q. So that puts us somewhere, if you called at 7:25, he's there somewhere around 7:35, maybe 7:40; is that correct?
A. Yes. Yes.
Q. And when Dr. Heiple got there, what did he do?
A. He assessed the patient. He assessed the infant and then talked to the dad and explained to me that Dr. Jones was on her way in, because that's the reason why all babies are coming to the nursery at the time, and then I explained to him, you know, he observed the baby on the warmer bed. He observed that the pulse ox was now up to 92, the 90s where we like it to be, and I said to him it's probably something transitional.
Q. What do you mean by that?
A. Transitional. Some babies need a little bit of oxygen. It's not uncommon for babies to need oxygen after delivery. It's not uncommon for babies to have respiratory issues after delivery.

So transitional, sometimes babies have respiratory issues that they need a little bit of O2 or a little observation, closer observation and things resolve. So transitional is just from in utero to actually taking real

breaths, so transitional is layman terms as I can put it for anybody who has a question about it.

Q. Was there a discussion between the two of you about whether this could be transition?

A. I did say I'm not sure if it's transitional or not. I just wanted to make sure you were aware and inform you and wasn't sure if there was anything else you wanted me to do.

Q. What was his response?

A. He again assessed the baby, talked to the dad and let me know that Dr. Jones was on her way in so she was in route driving.

Q. And I want to go back for a minute and ask you, you were shown a copy of your note and in particular that portion of your note which documented coarse breath sounds.

Was that coarse breath sounds before or after you suctioned?

A. I do not recall. It's been a very long time, but I will say my assessment on the baby initially was that the baby was dusky. I put a pulse ox on. We took action. I did vitals. All the other vitals were relatively stable. Coarse breath sounds are very common after delivery, too.

Q. Why is that?

A. Because babies' lungs are very wet until they start taking their first breath then the moisture absorbs and the breathing begins to circulate differently than in utero.

Q. One of the other things that I thought was pointed out on that note was the baby's nailbeds being dusky. Is that unusual with a baby of this age?

A. Acrocyanosis is very common. Acrocyanosis is the purpling of the hands and feet, but also, it was 12 hours after, I charted, so there's a lot that -- emotionally, everything. There's a lot of time expanding between.

Acrocyanosis is purpling of the hands and feet and that's very common in most newborns, but dusky also can be because, as the day progressed, she obviously ceased to breathe, so it's very hard to summarize something from a 12-hour status after being an extremely draining and traumatic day.

Q. I wanted to go back to something you said earlier about that. You've told us that the first thing that you noticed was that Kendall was dusky, correct?

A. Yes.

Q. It's because of that that you got up, went in, put the pulse ox on, put her under the oxy hood and that the grunting, flaring and retracting was something that occurred later in the progression; is that correct?

A. Yes, and until we stressed her when we started doing our labs, that's when the real grunting, flaring and retracting happened.

It's difficult to summarize every single thing I did and every single moment I did it and every single thing that I

observed, but it transitioned from a slightly dusky baby to a baby in respiratory distress.

Q. And this transition, was this over a period of time?

A. Yes.

Q. And did that transition occur over the period of time up to the time that Dr. Jones got there?

A. No. The baby was not in respiratory distress. I mean, there's many degrees of respiratory distress. The baby was observed as being dusky, and the situation was rectified by putting the oxy hood on.

It did not progress to anything worse until after we started doing the orders from Dr. Jones because we stressed the baby by, again, doing lab draws and trying to start an IV which makes the baby want to cry, so that's when things got -- things started to get worse.

Q. So just so I understand, in terms of the timing, I want to make sure we are absolutely clear on this, 7:25, it's just the duskiness that you noted?

A. Yes.

Q. You put her under the oxy hood. Does she pink up at that point?

A. Yes.

Q. So she is -- her color is better at that point?

A. Her color is better and her oxygen saturation is in the 90s.

Q. And I think we saw before, but let's see if we can pull this up, 1165, and this is Jamie's vital sign note, and if we can pull up the section -- I think it's the second section here. Go down further, the third section. 7:30. The pulse ox at that point is 94 percent; is that correct?
A. Yes.
Q. And at 94 percent, is she at that point pink?
A. Yes.
Q. Is she at that point, from your recollection, grunting, flaring and retracting?
A. No.
Q. So when Dr. Heiple comes in -- and you said you thought it was about ten minutes later; is that correct?
A. Yes.
Q. Was she pink at that time?
A. She is under the oxy hood still having oxygen being provided for her, supplemental oxygen. Underneath the oxy hood, she was stable.
Q. So when he saw her, she was -- your recollection was that she was stable at that point?
A. Yes.
Q. And at that point, she was not grunting, flaring and retracting; is that correct?
A. No.
Q. So when Dr. Heiple had finished his examination, spoke

with Matt, she was stable; is that accurate?
A. Yes.
Q. Is it accurate that she remained stable up through the time that Dr. Jones came in, according to her note, at 8:00 a.m.?
A. Yes.
Q. You told us that at that point, Dr. Jones evaluated her; is that correct?
A. Yes.
Q. What did Dr. Jones do?
A. She ordered a workup on her.
Q. Do you recall what the workup included?
A. Chest x-rays, CBC, blood culture, I believe cap gases.
Q. What are, for the jury, what are cap gases?
A. Just to see oxygen levels, carbon dioxide levels, see if the baby has anything for like an acid based balance, if you will. There's a balance that your body needs to be, so if you have too much carbon dioxide or too much of one thing, the balance is off, and it will be reflected in the baby's cap gas.
Q. So when Dr. Jones got there, did she immediately go to Kendall?
A. She assessed Kendall, yes.
Q. Did she do anything with that other baby at that point?
A. Yes.

Q. Did she assess that baby as well?
A. Yes.
Q. And after she assessed the baby, what did she do in terms of -- in addition to those orders, did she at that point begin making arrangements to transfer the child?
A. Yes.
Q. And did she tell you why she wanted to transfer Kendall at that point?
A. I do not recall timeline, but I know that there was labs that were returned and that she was already making progress towards shipping both the babies that were in the nursery at that time.
Q. You were asked questions about Dr. Jones' reaction when she came in. She was upset that she had not been called, correct?
A. Yes.
Q. She wanted to know why she hadn't been called?
A. Yes.
Q. And Dr. Heiple's response was?
A. You were already on your way in.
Q. And do you know how he knew that, other than the fact that she was always there at 8:00?
A. The residents are always contacted, the majority of the time, contacted by the pediatrician because they round together, that they are on their way in to gather the babies

to have their morning assessments prepared for debriefing that they do every morning.

Q. Do you know if that's what happened here? Was there some other way he knew she was on her way in?

A. I do not know.

Q. Now, in addition to the laboratory studies that you mentioned that she ordered, she also ordered that an IV be put in; is that correct?

A. Yes.

Q. And the purpose of that IV was to give the antibiotics. Did she order the antibiotics right away, too?

A. Yes.

Q. And you've told us that the IV was put in at around 8:20 that morning?

A. Yes.

Q. And did you put that in or did someone else put it in?

A. When you draw labs on a baby, it is a joint effort. You need more than the one set of hands, two sets of hands, sometimes you need three and four because babies are resistant, and babies are small, and sometimes their veins -- their veins are not developed as our veins are.

So you need a couple sets of hands to do peripheral sticks and to find a vein that we can start an IV on, so you need extra sets of hands.

Q. So the IV was inserted at 8:20. We've already seen a note

that indicates the ampicillin, one of the antibiotics that Dr. Jones was -- had ordered, was started around, looks like, 8:34, 8:35. Does that sound accurate?

A. Yes. Once an IV is in, once a septic workup is ordered, it's kind of a standard -- it is a standard procedure that we do blood culture, do a CBC, start an IV, get antibiotics and IV fluids going.

Q. And you do it in that order?

A. Yes.

Q. And the reason why you do it in that order is that you -- your blood culture will not be accurate if you've already started the antibiotics; is that correct?

A. Yes, that is correct.

Q. So you have to get the blood culture first so you get an accurate read on the blood culture about what organism might be growing; is that correct?

A. Yes.

Q. And it's after that you get those blood cultures that you can then start the antibiotics?

A. After you draw the blood culture, yes.

Q. Now, the entire time that -- from 7:25, Dr. Heiple comes down until Dr. Jones gets there around 8:00, Dr. Heiple is there the entire time, correct?

A. Yes.

Q. You are there the entire time?

A. Yes.
Q. You are both watching, monitoring this baby, correct?
A. I never left the nursery.
Q. And when Dr. Jones got there, other than the time that she went to talk to the parents about transferring this child, was she there the entire time too?
A. Yes.
Q. Now, at some point, she leaves the nursery to go talk with the parents. Did you go with her for that?
A. No.
Q. Do you believe Dr. Heiple went with her, or did anyone go?
A. There may have been a supervisor. There may have been another nurse, maternity nurse on. Chelsey Paff was taking care of the patient, the patient's mother.
Q. Carissa?
A. Carissa, sorry. So she may have been present, but I never left the nursery.
Q. You've told us before about the progression. You told us that things didn't, grunting, flaring and retracting, until after you started interacting with the baby, taking blood work, starting the IV, that type of thing.

Can you tell the jury what you recall after that? The IV has now been in. What happened after that? You've applied the antibiotics. What's next?
A. Results are back. Dr. Jones reads the results of the cap

gases. Also -- she is also coming back from receiving -- I'm sorry. I don't know the exact timeline and the exact specific way that things went down, but once the cap gas results were back and Dr. Jones came back to the nursery and once we were doing an invasive procedure, stressing the baby, the baby's color and pulse ox -- the oxygen demand was increasing.

Dr. Jones immediately came in and said we need to intubate this kid now because she saw that it was not looking the way it looked when she first saw it on the warmer bed with the pulse ox in the 90s.

Q. I'm going to put up a couple copies of your notes. This is page 1116. I think these are -- this is the handwritten note there, some of your documentation. Is this your documentation or is this somebody else's?

A. This is a combined documentation. Whenever we do an infant transfer, it's a group effort, and a lot of this information, I was trying to gather for West Penn, so whenever their transfer team came, they had an idea of what was going on and the timeline that things were given, so it is not gospel, but it is the best of my ability in the moment of trying to organize for West Penn's transfer.

Q. Okay. So you have documented here it looks like around -- correct me if I'm reading this incorrectly -- 8:30 is a chest x-ray was done?

A. I can't say that that's a specific time that the chest

x-ray was done, but in the event of getting labs drawn and an IV started at 8:20, the chest x-ray was also in.

We called them to let them know before the order even goes in that we need them to come down, because we can't take the baby to them because of security purposes, so we let them know we have an order coming in. If you don't get it, we need this x-ray before you even get the order. They are aware and they are in route.

Q. We saw some chest x-rays that were timed earlier. I shouldn't say "timed earlier." We saw some x-rays with various times on them. You have under 9:00, CBC, cap gas, IV started, blood culture, but we know that happened earlier; is that correct?

A. Yes. That column where it says procedure, meds, results, comments, it was my order of what we were doing. They don't fall with the times. Those are more so for vital signs when I have that written down.

On the other where it says status, that is just for vital signs that were collected throughout the time and what the pulse was.

So the timing of when the chest x-ray, CBC, the cap gas, the IV, that is a general timeline that I put around the 8:30 time because that's when the orders were received for us to start things and we got the ball rolling around 8:00. We got her IVs. It takes a long time to start a baby's IV, and

sometimes we are unsuccessful to start IVs. Not for any reason other than some babies are very difficult to get IV starts on.

Q. In terms of Dr. Jones intubating the child, I've seen several different things. I see a 9:40, I see a 9:50. In her notes, she said 9:40. Again, do you know what time exactly that occurred?

A. I do not recall. Again, I was hands-on on the warmer bed with that baby. I never ever left her side for anything but collecting things that the doctors needed.

Q. Was that baby intubated before the West Penn team got there?

A. Yes.

Q. After the West Penn team got there, did they then take over the resuscitation of the baby?

A. Yes. There is a doctor. I don't know the doctor's name.

Q. Is it Leneri?

A. It could be, yes, I'm sorry. But the West Penn team is in charge of the transfer out. We're in charge of stabilizing the baby until the team gets there, and it was a joint effort to attempt to stabilize and keep Kendall stabilized, and unfortunately, she never got stable enough to be transferred.

Q. I'm not going to ask you to go through that. The records -- are you okay?

A. Yeah, I'm good.

Q. The records reflect that they got there around 9:45 and that the code was eventually called at 11:40. Is that consistent with what you can recall?
A. Yes.
Q. And from your reaction, I assume this was really traumatic for you?
A. It was a traumatic day for everybody.
Q. This isn't something that normally happens in the nursery, does it?
A. No, not typically.
Q. The entire time that this baby was being resuscitated from the time that they got there, the West Penn team at 9:45, until the code was called, was Dr. Jones there with you the entire time?
A. Yes.
Q. And you were --
A. From the moment she intubated until the baby was ceased to breathe.
Q. After the baby passed, did you go with Dr. Jones to talk with the family?
A. Dr. Jones did on her own. I took time to console them when I had a moment to just send my apologies and wish that I could take things back or do something different that would, you know, that their baby would still be here. I just wanted to console them.

Q. And that was my next question. Did you speak with Matt and Carissa?
A. Yes.
Q. Was it that day or was it the next day?
A. That day. I don't believe I worked the next day. I honestly do not recall, but I just wanted them to know that my heart was with them.
Q. And in terms of Dr. Jones, did you ever have a conversation with her after this all happened about what happened?
A. We would debrief a little bit. I would see her in the mornings for rounding when I was in the nursery and discuss, you know, cause. What questions -- we had a lot of questions and, you know, it was very difficult to handle that emotionally, professionally, so there were conversations in passing and professionally with Dr. Jones.
Q. The reason why I ask the question, that day, when this was all happening, was it the situation that there was -- that you were aware of some explanation, or was it we don't know what happened?
A. There was a we don't know what happened question mark and just waiting for results to come back to explain.
Q. And did you learn at some point after that day that the blood cultures and the tissue cultures came back showing that this child had an E. coli sepsis?

A. Yes.
Q. And had you ever seen a baby with E. coli sepsis like this before?
A. No.
MS. KOCZAN: Thank you.
THE COURT: Mr. Price, any additional questioning of this witness?
MR. PRICE: Just a few.
REDIRECT EXAMINATION
BY MR. PRICE:
Q. Just to follow up on this. When you were talking about this transitional breathing and the coarseness in the chest, you knew why Kendall had coarseness in her chest, correct?
A. I observed coarseness in the chest and I deep suctioned and there was meconium present. Coarseness in the chest doesn't always mean meconium. I've heard coarseness in chests of many patients that don't have meconium. There's multiple reasons that coarseness could be the reason.
Q. But you suctioned out a lot of junk. It was in a tube and it was meconium, correct?
A. I deep suctioned meconium out of Kendall, yes.
Q. Did you show that tube -- I know you showed it to Dr. Heiple. Did you show what was in that tube to Dr. Jones?
A. Yes.
Q. Let me ask you this, and I know this is very difficult, so

Kendall didn't survive. I know you were dealing with another baby who had a lot of other issues, too.

Did that baby survive, the baby that was in the nursery that morning?

A. Is that important to this case?

Q. Yes, it could be, because we are talking about an emotional issue, and if the hospital lost two babies in one day, that could be very emotional.

A. Okay. I just didn't know that was important. From my -- I don't have anything factual on paper. I have hearsay that, yes, the baby survived its transfer.

MR. PRICE: Thank you.

THE COURT: Mr. Colville, anything?

MR. COLVILLE: No.

THE COURT: Ms. Koczan, any additional questions?

MS. KOCZAN: Just one additional question.

RECROSS-EXAMINATION

BY MS. KOCZAN:

Q. In terms of what you suctioned out, you talked about you saw meconium. There was mucus in there, too?

A. I'm sure there's mucus. I don't know the actual content. I know what meconium looks like. I know what mucus looks like. I'm sure there's meconium in there. I'm sure there's mucus in there, but there's also many babies that have lived after meconium has been suctioned out of their lungs, so

that's very important to understand that it's not just -- it's not just meconium. There is a lot of other complications, that that baby was very sick.

Q. And that was, you learned later, because of the E. coli sepsis?

A. Yes.

MS. KOCZAN: Thank you. Your Honor, may she step down?

THE COURT: I think I have one question.

Nurse McCrory, I think that you advised Mr. Price that you were there when Dr. Heiple was talking to dad, Matt; is that right?

THE WITNESS: Yes.

THE COURT: Were you part of that conversation?

THE WITNESS: I was.

THE COURT: Do you recall what they were talking about?

THE WITNESS: I was present for the conversation, but I do not recall what Dr. Heiple said to Matt. I can tell you what I said to Matt myself because when we had to do lab draws on Kendall, initial introduction with Matt, met him, I always want to know the baby's name. I write it down. It's something in me as a nurse, and I explained to him that it could be something transitional, and transitional, again, is a big word if you are not in the medical field as to what that

is, and said baby might just be having a hard time transitioning from being inside mom to the outside. We're going to do some lab draws, and I'm going to have you step out unless you have any other questions, because I don't want -- parents get a little upset and worked up if they stay present for when you are poking or prodding a baby, and they are getting stressed out.

So he had questions in regard to the baby's head. I explained to him that's normal, coming out of a vaginal delivery, first-time mom. Those are normal things, and usually the babies' heads, within the first two, three days of life, go back to normal. So he had questions.

Dr. Heiple discussed -- talked to him, and the dad had left, so I do not know specifics of what Dr. Heiple said to Matt, but I know my conversation with Matt.

THE COURT: Okay. Thank you. The court has no further questions.

Does that questioning prompt any additional questions?

MR. PRICE: Yes, Your Honor.

Matt, can you stand up for a second?

REDIRECT EXAMINATION

BY MR. PRICE:

Q. I want to make sure that everything you said was said to this gentleman (indicating)?

A. Yes.

THE COURT: You are indicating, Mr. Price, to Matthew Fritzius?

MR. PRICE: Yes.

Q. You had that whole conversation with him?

A. Yes, I did.

THE COURT: Anything further then?

Nurse McCrory, thank you for your appearance here today. You may step down, and I think everybody has signaled you are also excused.

THE WITNESS: Thank you, Your Honor.

THE COURT: We appreciate you being here.

(Witness excused.)

THE COURT: Mr. Price, your next witness.

MR. PRICE: Dr. Bradley Heiple.

THE CLERK: Sir, will you step forward, please?

THE COURT: Dr. Heiple, please approach my deputy to be sworn.

THE CLERK: Please state and spell your name for the record.

THE WITNESS: Bradley Heiple, B-R-A-D-L-E-Y, last name H-E-I-P-L-E.

(Witness sworn.)

THE COURT: Thank you, Doctor. Watch your step. Arrange yourself. Make sure you are speaking into the

microphone so everyone can hear you.

BRADLEY HEIPLE, M.D. a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PRICE:

Q. Dr. Heiple, good afternoon. Could you please tell us your full name and what do you do for a living?

A. Sure. My name is Bradley Heiple, Dr. Bradley Heiple. I work currently as a family practice physician with Heritage Valley at an outpatient only practice near Robinson Township right now.

Q. And just so the jury understands family practice, what does that involve?

A. Sure. Family practice is a nonsurgical specialty of medicine that encompasses care of individuals all the way from birth all the way to end of life issues, so it's pretty much full scope nonsurgical medical practice.

Q. So you could take care of babies, adults and senior citizens?

A. Correct.

Q. And you work at one of the satellite offices, so it's sort of like an urgent care, not really, or do you see patients on a continuing basis?

A. Continuing basis. There's continuity of care. It's your basic general practice that you would go to for primary care,

ankle, physicals, things like that.
Q. We're going to go back five years back to 2014, and can you tell us back in 2014 what were you doing?
A. Sure. So I was in my residency. I was in my second year of residency actually at Heritage Valley where I work now. They have a family practice residency training program there, and I was a senior resident, so second of three years of training, and at the time we are talking about, I was on a pediatrics rotation as one of the specialties we focus on throughout our training.
Q. Let's go back a little bit more so the jury understands. Where did you graduate from college?
A. Undergraduate, I went to Grove City College. Graduated in 2009, degree in molecular biology. Then I did my medical school at Lake Erie College of Osteopathic Medicine from 2009 to 2013.
Q. And from what I understand, of course, being a doctor of osteopathic medicine, you have to do a residency?
A. Yes.
Q. That's what, through Heritage Valley Beaver, they would allow you to come in and be a resident at that hospital?
A. That's correct.
Q. Now, tell the jury a little bit more about residency so they understand it, and I understand that in July -- I'm sorry, October of 2014, you were on a month-long residency in

a specific type of medicine?
A. Right.
Q. So that would be pediatrics?
A. That's correct.
Q. And then the month before, do you know, were you in a different practice?
A. I don't remember where I was in the month before. We would rotate through various specialties about every four weeks in the residency, being pediatrics, inpatient adult medicine, obstetrics and gynecology and a few other electives, outpatient medicine. I can't remember what I had at that point. I know at that point I was on pediatrics though.
Q. In osteopathic medicine, did you study any specific pediatric medicine besides the general pediatrics? Did you have any specialty in pediatrics through your teaching or your school of osteopathic medicine?
A. Yeah. We did a pediatrics rotation in medical school. I believe a couple. I can't remember exactly how many I had, and then in family medicine, as I chose to become a family practitioner when I was in residency, because you will occasionally see kids in your practice, they did have, I believe it was four months of dedicated pediatric rotation throughout training.
Q. And would that four months be at one time or was that four months over your entire residency?

A. It was spread out over the three years. There were two first year when you are an intern or first year resident and you have one in second year and one in third year of residency.

Q. In October of 2014, you were in your second year of residency?

A. That's correct.

Q. So this would have been, in essence, the third month, third rotation that you had in pediatrics?

A. That's correct.

Q. So let's get to October 13, 2014. It's a Monday morning, correct?

A. Correct.

Q. And I'm going to -- there's a little PowerPoint I have, so it's 7:25 in the morning, and Nurse McCrory notes an oxygen level of 81. She records grunting, flaring and retracting. The baby appears to be in pain, nasal flaring, grunting, substernal retractions, respiratory is labored, breath sounds coarse and she contacts a resident, correct?

A. That's correct.

Q. Now, here's where we get to a little bit of a dispute, correct?

A. Sure.

Q. And that is that you believe that you were not contacted until 8:00, correct?

A. During my deposition, I did say that I thought it was at the end of our lecture hour, we had discussions about that, that ended around 8:00. That was my recollection at the time. Just a mental snapshot I had.

Bear in mind, the deposition was a couple years after so the timing of it could be a little bit foggy. I know it was during the lecture hour whenever I received the call.

Again, when I testified, my recollection was that it was at the end of the lecture hour which would have been around 8:00 on most days but there is a chance that it may have been earlier.

Q. Just so the jury understands what you said in your deposition, I copied it out and you said, "Starting from the beginning, so we got called around 8:00. I just remember we were leaving our lecture hour which ended at 8, and I got a call on my pager from the nursery just saying, hey, we have this baby that was born earlier this morning. You know, we were doing our assessment, and her oxygen levels were down, and I believe it was in the 80s."

Do you remember saying that?

A. I do.

Q. And then, so you told me in your deposition, it was a few minutes later, you and your intern -- you had an intern working with you, correct?

A. Correct.

Q. You went down to assess the baby, and whenever -- you were told the oxygen saturations were in the low 80s, mid to low 80s, correct?
A. Correct.
Q. You listened to the lungs and you heard they were clear; is that correct?
A. Correct.
Q. You believed this was some type of transitional routine syndrome?
A. Correct.
Q. She was on oxygen and it came up to the mid 90s and you made the decision to wait for Dr. Jones to come in, correct?
A. Correct.
Q. You did not deem the situation with Kendall to be critical or deteriorating, correct?
A. Correct.
Q. Now, so we are at a few minutes after 8:00, and then I asked you when did Dr. Jones come in. I said after your examination, how long was it until Dr. Jones showed up. You said I would say no more than 15 to 20 minutes; is that correct?
A. Yes, I was saying that.
Q. So you believe that it was around 8:20 that she showed up?
A. I believe that it was 15 to 20 minutes after I received the call and did the assessments and waited with the baby, and

then she came around that time frame.

Again, had the call come in at 8:00, then, yes, I would say 8:15 to 8:20, but again, like I said, there is -- you know, I may have not remembered correctly what time I was called just because it had been so long, but I do remember it was probably in the neighborhood of 15 minutes or so from the time I received the call that she came in.

Q. I'm trying to establish the time of the call. If you could take that out. We're going to play this clip from your deposition to see if this refreshes your recollection. Could you play BH009.

(Video playing.)

MR. PRICE: Then if we could play BH010.

(Video playing.)

BY MR. PRICE:

Q. So back in 2017 when I took your deposition, you were doubly clear that it was after 8:00 that you got down to see Kendall, correct?

A. At that point, yes.

Q. Could we go back to the PowerPoint? Then Dr. Jones came in and this is what she found, that the baby was grunting, flaring and retracting, coarse breath sounds, working to breathe, respiratory was labored with the abdominal muscle use and subcostal retractions, correct?

A. Correct.

Q. She immediately ordered a chest x-ray, CBC, cap blood gases, IV started and called for a transport, correct?
A. Correct.
Q. I walked in that morning. They told me I had a sick baby, and I said why didn't you call me. They said we knew you were going to be here any minute, correct?
A. Correct.
Q. So after your examination, you just thought she's going to be coming in. Just wait and see what happens, right?
A. At the time when I assessed the patient, the oxygen levels and vital signs were within normal limits. She had responded well at that point to supplemental oxygen.

This is a situation we had seen with previous patients that I was familiar with, and oftentimes, I would, you know, give a period of observation before making the call to, you know, assess whether or not we needed to pursue further workup or not.

Based on working with Dr. Jones in the past, as this had not been the first day I worked with her, I knew kind of when she would come in. I believe the pediatricians have office hours after they round in the hospital. I knew the basic time frame she would be in, so my thought was let's watch the patient for a few minutes here, see if she comes in, and sure enough, she did come in shortly thereafter.

Obviously, had things begun to deteriorate rapidly, I

would have called her or if she had not showed up in a timely fashion, I would have called her.

Q. You decided to wait and watch, even after Nurse McCrory showed you a suction tube filled with dark thick green meconium, correct?

MS. KOCZAN: Objection to the form of that.

MR. COLVILLE: Objection.

A. I don't remember saying that.

THE COURT: Sustained.

Q. You don't remember that Nurse McCrory showed you a suction tube with meconium in it?

A. I do not recall.

Q. Would that have been important to your assessment of Kendall to know whether or not, before an oxy hood was placed on her, whether or not she was suctioned?

A. Any kind of information that would have happened during the birth or the labor or after would have been important. I just don't recall getting that piece of information or seeing that piece of equipment.

Q. So if a baby, before an oxy hood is put on and suctioned meconium out that is dark green, that would be concerning to you, correct?

A. It would be a relevant piece of information.

Q. And something like that would be concerning as to whether or not this type of respiratory issue was transitional or not?

A. Potentially.
Q. And potentially, a pediatrician would want to know that immediately, correct?
A. Absolutely. Any information would be helpful in these types of situations.
Q. And your assessment though was everything was normal with Kendall, correct?
A. From a vital signs standpoint and the basic exam, the head to toe assessment I did, I didn't see anything that was critical at the time that would deem --
Q. You actually listened to her lungs, too?
A. I did.
Q. Whenever you listened to her lungs, everything was fine?
A. Sounded clear to me, yes.
Q. Just so we understand, an hour and a half later, there's an x-ray that's done -- not even an hour and a half later, a half an hour later, this x-ray is done, and it shows that there's meconium aspiration and/or neonatal pneumonia, correct?
A. Correct.
Q. And you didn't hear any of that?
A. I did not hear anything, no.
Q. So at 7:25 when Nurse McCrory does an examination, she notes that -- everything with Kendall. There are a whole bunch of abnormalities with her breathing, with her

respirations, coarse sounds, correct?
A. Correct.
Q. You come in, it's either 7:35 according to Nurse McCrory or 8:05, according to you, and it's a normal exam, correct?
A. Yes.
Q. And then 20 minutes later, Dr. Jones does her examination, and what she finds is that -- she finds the same things, the same abnormal findings that Nurse McCrory found, correct?
A. Correct.
Q. Now, it wasn't until 8:32 that the orders for blood gas and the chest x-ray and the blood count were ordered, correct?
A. Correct.
Q. So that was at least an hour from the time that Nurse McCrory said that she called you, correct?
A. Correct.
Q. Do you agree with this safety rule: A hospital must take all precautions to minimize risks to its patients?
A. Absolutely.
Q. Do you also agree with this safety rule: That the earlier you treat something, the better the outcome?
A. Absolutely.

MR. PRICE: That's all the questions I have.

THE COURT: Mr. Colville?

MR. COLVILLE: No questions.

THE COURT: Ms. Koczan?

CROSS-EXAMINATION

BY MS. KOCZAN:

Q. Good afternoon, Doctor. I want to go back for a moment or two to ask you some background questions. I know you were asked about where you went to medical school. When did you begin your residency at Heritage Valley?

A. So we started in July of 2013, so shortly after I graduated from medical school.

Q. And you told us that up through that time -- "that time" being October of 2014 -- you had done two pediatric rotations; is that correct?

A. That's correct.

Q. And during those pediatric rotations, correct me if I am wrong, I'm assuming you would have seen newborns?

A. Absolutely.

Q. And during those pediatric rotations, is it the situation that one of your responsibilities every day on the rotation is to go through the nursery, evaluate babies?

A. Correct.

Q. Newly born babies?

A. Correct.

Q. So you had seen babies who had issues with transitions before; is that correct?

A. That's correct.

Q. Had you seen babies who had infections before?

A. Yes.
Q. So your evaluation of Kendall that morning wasn't the first one you had ever done; is that correct?
A. That's correct.
Q. Can you give the jury some estimate of how many babies routinely would be in the nursery on a normal day?
A. Sure. It did vary pretty widely. I'd say, on average, usually there were anywhere from maybe six to eight newborns at that time on the service at any given time, and those would turn over usually every two to three days. They would be discharged, and there were enough deliveries that it usually maintained five or six babies you would be seeing. Sometimes more; sometimes less on a given day.
Q. When you were on your rotations, is it Monday through Friday, or is it seven days a week?
A. For the pediatric duties, it was Monday through Friday, and then the interns and the senior would take turns rounding over the weekends on Saturday and Sunday.
Q. And the first two rotations, they were each four weeks long?
A. That's correct.
Q. So you had had eight weeks of pediatrics, and then this was your --
A. This would be the third.
Q. The third rotation, so do you know how far along you were

in that rotation at that point?
A. I honestly don't remember what week it was of the rotation. I don't think it was the first one, but I can't be sure. I would have to look back at the schedule.
Q. You've told us that you were with Dr. Jones before?
A. That's correct.
Q. And you knew what her routine was; is that correct?
A. That's correct.
Q. And what was her routine about getting to the hospital?
A. Usually, if I remember correctly, as it's been a while now, she would usually get there around 8:00. She was usually there right around when lecture would be over, and she would usually either be down there or just getting there around that time.
Q. And that was something that you had observed her doing?
A. In the past.
Q. First two rotations and then this rotation?
A. Yeah, correct.
Q. And was there any other way for you to determine if she was on her way in other than simply knowing that it was her practice at 8:00?
A. Yeah. They actually -- at Heritage Valley, they have like a parking board. It's just an app on a computer you can click and see, based on whoever swiped into the lot, when certain doctors are in-house or when they left.

So it was a nice way to know on that rotation and other rotations when your attending physician or your supervising physician was in the house. It was just a nice way to be able to tell what time they were there, when they were there so you can be prepared when they got there.

Q. Do you have a recollection on this day if you accessed that to know that Dr. Jones was in the house and on her way?

A. I believe I did have it up, just because I knew obviously the situation she would want to know about, and I wanted to make sure she was there, and like I said before, had she not arrived within a few minutes, I definitely would have called her at that point.

Q. So I want to go back now and talk a little bit about what happened at various times. The jury has already heard that, according to Jamie's documentation, that around 7:25, she noted that the baby was dusky, got up, put a pulse ox, oxy hood. When she called you, did she tell you all of that?

A. I only really recall hearing about the oxygen saturations. I don't remember the exact nature of the conversation though. That could have been said. I don't have a recollection of that though.

Q. You were shown a copy of Jamie's note from 7:25?

A. Correct.

Q. She just testified a little while ago in the courtroom. You were not present?

A. Correct.
Q. You don't know what she had to say --
A. That's correct.
Q. -- about what was in the note and when those things occurred?
A. That's correct.
Q. I'd like you to assume that Jamie has testified that at 7:25, what she initially noted was that the baby was dusky, and it wasn't until after they began interacting with her, and by that I mean, you know, sticking her to get blood work, the IV, that type of thing, that she began grunting, flaring and retracting.
A. Correct.
Q. If that was her testimony, would that be consistent with what you saw when you came in?
A. The grunting, flaring and retracting?
Q. No. That there was no grunting, flaring and retracting at the time when you came in?
A. Right. When I assessed the patient, I do not recall seeing any retractions or grunting or flaring or anything like that.
Q. So you get the call. You've told us that you were -- I thought you said grand rounds; is that correct?
A. Yes. It was something like that, a lecture hour that happened every day.

Q. And the lecture started at what time?
A. 7:00.
Q. And did it always end at 8:00?
A. No. It would frequently end earlier. Sometimes it would go over.
Q. And as you sit here today, do you have any recollection what time this lecture on that day ended?
A. I couldn't tell you that.
Q. And did you know back in 2017 when you were deposed, what time the lecture ended on that particular day?
A. I did not.
Q. So we're clear, you get the telephone call. What do you do?
A. So we immediately proceeded to the nursery. I had gotten these calls before obviously, so we knew it was something that needed to be looked at right away, so we picked up and went right down.
Q. Where was this lecture in the hospital?
A. The lecture was on the second floor.
Q. Where is the nursery in comparison to the lecture?
A. Nursery is on basement level, so it was two floors up and just down the hallway.
Q. There are elevators at Heritage Valley?
A. We did.
Q. Did you take the elevator down?

A. No. We ran down the steps.
Q. You ran down the steps because you were in a hurry and wanted to get down there?
A. Correct.
Q. So you ran down the steps. Can you give the jury some estimate of how long from the time the jury called -- excuse me. I'm saying "jury" too much. From the time Jamie called you until the time you got down to that nursery?
A. Probably wouldn't have taken more than one and a half or two minutes to get down there. Not a very long walk.
Q. So you come to the nursery and you told -- you said before "we." It was you and another, was it an intern?
A. Correct. It was a first year resident that I was working with at the time.
Q. Who was that?
A. Dr. Alyssa McKenna.
Q. And so you and Dr. McKenna come into the nursery. Do you go immediately to Kendall?
A. Yes, correct.
Q. Do you have a conversation with Jamie at all about what's been going on since the time you got the call until the time you see Kendall?
A. I think she was talking to me throughout this, kind of filling me in. Again, I don't remember the exact nature of what was going on. I was more concerned at that point of

getting the patient, assessing the patient and seeing what was going on from my own eyes, from my own vantage point.

Q. At the time you got there, were you aware, based upon what Jamie told you, that when she put the pulse ox on initially, somewhere around 7:25, that the pulse ox was 81?

A. Yes. I do remember that was part of the conversation on the phone. I do remember that piece of information.

Q. By the time that you got there, had the second pulse ox check already been done?

A. Yes. She was actually on a continuous monitor so we were able to see heart rate and oxygen levels in the blood at that point live, and at that point, I believe it was in the mid 90s. 94, I want to say.

Q. There's documentation in this chart by Jamie that at 7:30, the pulse ox was 94 percent?

A. Okay.

Q. Do you have any reason to dispute that?

A. I don't.

Q. So you come in and can you tell the jury what did you do? You have this conversation with Jamie. Are you with Kendall at that point?

A. Yes. We were standing by the warmer where she was.

Q. Can you tell the jury what you did?

A. Yes. We just did a basic head to toe assessment.

Q. Let me stop you there and ask you to explain, because you

may know what a basic head to toe assessment is, we may not. Can you explain that?

A. Absolutely. First of all, just observing the patient, looking at color, looking at muscle tone.

Q. Let me stop you. Looking at color, what was her color at that point?

A. I believe she was pink at that point. I don't remember seeing a lot of cyanosis, which is a blue discoloration or any discoloration or paleness or anything like that.

Q. If there had been blueness in her finger nails, I think Jamie termed that as acrocyanosis, would that have been unusual?

A. Not necessarily. That's a very common thing you see in newborns that are transitioning from inside the womb to breathing air. You see a little bit of blue discoloration usually in the hands and feet. That usually resolves within a day or so.

Q. So you took a look at her color?

A. Correct.

Q. What was next?

A. Looking at tone, muscle tone. She was laying flat on the bed. She was moving her extremities, so that's always a reassuring sign as well.

Q. Why is that?

A. Well, if a baby is sick or going through some sort of

infection or some sort of systemic illness, usually they become a lot more limp. They lose muscle tone. That's one of the first things you see that changes.

Q. And she had good muscle tone at that time?

A. At that time, she did.

Q. So what was next in your assessment?

A. Then I did listen to the heart and lungs with my stethoscope. Of note, it can be difficult to examine a baby's breathing and cardiovascular exam just because of some of the fluid and things like that in the throat. We hear a lot of other accessory sounds, but I didn't hear anything that was particularly concerning at that time.

MR. PRICE: Your Honor, I'm going to object at this point with the caveat I want to ensure that Dr. Heiple is testifying solely from his memory about all of this.

THE WITNESS: Yes.

THE COURT: Go ahead, Mr. Price.

MR. PRICE: Because I will ask him where the notes are, but I just want to make sure that he is testifying from memory at this point.

THE WITNESS: Yes.

THE COURT: Go ahead, Ms. Koczan.

BY MS. KOCZAN:

Q. Doctor, you were telling us about -- let me ask you this: At the time you got there, had Jamie already suctioned

Kendall?
A. I don't know at that point.
Q. If she had already suctioned her, would that explain why perhaps she heard coarse breath sounds and you didn't?
MR. PRICE: Objection, Your Honor. That's pure speculation.
Q. From a medical perspective.
THE COURT: Sustained.
Q. Doctor, if a patient is suctioned, what effect does that have?
A. Sometimes you can remove some of the like mucus-esque secretions and some of the things you have from just being born out of the air canal and help you breathe a little bit better that way, especially out of the nasal passages.
Q. Was the word you used mucus-esque?
A. Mucus-esque, mucoid secretions.
Q. Are those what are responsible for coarse breath sounds?
A. They can be.
Q. So you don't know one way or the other whether Jamie had already suctioned her by the time you got done?
A. I do not know.
Q. When you listened to her lungs, you said it sounded okay?
A. From my perspective, I remember I didn't hear anything that really concerned me at that point.
Q. Okay. The next thing you said you listened to her heart?

A. Correct.
Q. Do you remember anything unusual there?
A. Nothing unusual there, and I was looking at the heart rate on the monitor, and I believe it was in the 140s.
Q. You talked about this monitor. What is displayed on the monitor? Is it an EKG tracing or just a number?
A. It's a number with a waveform that you see. They have one lead on the chest so it keeps track of that and it keeps track of oxygen levels with the probe that's on there, on their extremities.
Q. And the number with the waveform, that would be her heart rate; is that correct?
A. Correct.
Q. And there's -- is there another waveform for the pulse ox?
A. Yeah.
Q. And there's a waveform, and is there also a corresponding number with that?
A. There's a number with that, correct.
Q. So is it the situation that once that device is on, you can continuously see from second to second what's going on?
A. Correct.
Q. So you looked at that. What was next in your assessment?
A. Those were the big things. I just wanted to do a basic assessment, kind of what we talked about there, and then observe how she did over the next couple of minutes with the

oxygen to see what the numbers were doing, if they were trending in a worrisome direction. Those were the biggest things I did at that point.

Q. After you did that assessment, what were your thoughts at that point about what was going on?

A. At that point, the next step in the process is to kind of assess what are the possibilities. Is this something life threatening? Is this something, like we talked about, a transitional syndrome that you see in a lot of kids and just kind of go through that diagnostic process?

At the point, based on what I had seen and based on the numbers, as they were in the reassuring range at that time, I deemed that this could very well be a transitional syndrome which we had dealt with before, and I thought, because the numbers weren't deteriorating at that point and going down into a more worrisome range, that I was okay watching for a few minutes at least until Dr. Jones came up, and we would discuss it at that point.

Q. At that point, you told us you believe you accessed -- was it on an iPad or something? How would you access like knowing she had checked into the parking lot?

A. Correct, into the doctor's lot. It probably was on my iPad. They issued us iPads, and we were able to access the electronic medical record that way.

Q. And you could access that doctor's parking lot information

too?
A. Correct.
Q. So do you believe that you would have known at that point that she had already checked in and was on her way?
A. Correct. Correct.
Q. So did you talk -- do you have a recollection of talking with Matt, the baby's dad?
A. Personally, no, I do not.
Q. Jamie testified that she recalls you talking to Matt. Would you have any reason to dispute that?
A. I don't have any reason to dispute it. I don't remember the conversation though.
Q. So what happened next?
A. So Dr. Jones did arrive in fairly short order. I think we said 15 to 20 minutes. That sounds about right, and then she did her assessment and made the decisions from there.

At that point, I became more of a helper, so to speak. I kind of sat in the background. I didn't want to get in the way and let things happen as they happened.
Q. When Dr. Jones came in, was she -- did she say anything about being contacted or not being contacted?
A. Yeah. We actually did -- she actually asked me why she hadn't been contacted at that point. I basically told her what I told you. I knew she was coming in within a few minutes, and she was -- and I did tell her that had she not

been there in a timely fashion, I still would have given her a call.

Q. I want to explore that a little bit more. When you had that conversation with her, she told you -- she asked you why wasn't I called. Is that what she said?

A. That's correct.

Q. So are you aware, based upon the conversation you had, that she had not received any calls before arriving; is that accurate?

A. That's correct.

Q. That's why she was asking you the question?

A. That's correct.

Q. And after she got there, did the two of you then work together?

A. Again, I was more in the background at that point. I mean, I was helping her out with some of the computer things we had to do and things of that nature, but I let her do her assessment and make her judgments at that point.

Q. When she got there, by the time she got there, had there been a change in the baby's condition?

A. I don't remember if the numbers had declined at that point or if the oxygen levels had dropped. I don't think they had, but I couldn't tell you with certainty at this point.

Q. You were letting her take over at that point; is that correct?

A. Correct.
Q. So whatever was going on, we should ask her and she could tell us?
A. Correct.
Q. We've seen orders that have your name on it but were entered by Dr. Alyssa McKenna.
A. Correct.
Q. Those were Dr. Jones' orders; is that correct?
A. That's correct.
Q. And they are timed, I believe, for 8:32. The timing of that, is that when you actually -- when Alyssa actually sat down to the computer and typed them in?
A. I presume. I'm not sure exactly how the computer system works in terms of timing, but I presume that's when they were actually entered into the system.
Q. When Dr. Jones got there and finished her assessment, did she immediately give orders?
A. Yes.
Q. And then the orders were entered at some point later; is that correct?
A. Correct. I don't remember there being a big delay in terms of when we decided to start all this treatment and when the orders went in, but it was all in the same -- essentially the same time frame.
Q. So the orders go in. We know they are sometime around

8:32, but there was an IV inserted around 8:20. So in order for that to happen, would the nurse already have had to have an order, verbal order --

A. Probably a verbal order.

Q. -- to start an IV?

A. Correct.

Q. We know from looking at the records that the ampicillin was hung around -- somewhere around 8:34, 8:35, so there would have to be an order for that in order to get it from the pharmacy up to the unit to give it to Kendall?

A. That's correct.

Q. Is it the situation that you give verbal orders, the nurses start acting on it, and then you put them in the computer so they are covered?

A. Yes, that's how the process would go, often just to save time.

Q. And Jamie called you --

A. Correct.

Q. -- at 7:25 or thereabout. Why did she call you as opposed to Dr. Jones?

A. Part of our duties as resident or in training physicians throughout the pediatric residency and some of the other programs or some of the other rotations were to field the calls on the floor since we were the ones in the hospital.

The pediatricians and some of the other specialists would

often be at their office hours. It would be a nice way to get the information to the doctor to move it up the chain of command. It was actually very commonplace for nurses to call us first whenever something would happen in the hospital.

Q. We've heard testimony and we saw in the opening, I think in my opening time when Dr. Jones at some point went and spoke with the family about transferring Kendall up to Pittsburgh.

Were you with her when she went to speak with them?

A. I was.

Q. Do you remember anything about that conversation?

A. I don't recall specifics. I remember we just went down and her basic spiel at that point is we are going to transfer the baby for precautionary reasons. We think there might be a chance that this could decline, so we just want to get her on to a tertiary care center where she can get a higher level of care at that point, if needed.

Q. From your recollection, did the parents agree to that?

A. I believe so, yes.

Q. After you talked with the parents, did you then go back to the nursery?

A. We did.

Q. And did you then stay up until the time the transport team came?

A. Yes, yes.

Q. And can you tell the jury generally what was going on

during that time frame, from the time you get back from talking with the parents up until around and we've seen 9:45, is when the transport team arrived, just generally -- we don't have to go minute by minute -- but generally what was going on?

A. Mainly observing the patient, watching for any subtle changes or any critical changes that would necessitate more urgent action, number one.

Number two, I think we were doing some of the computer work, and I think Dr. Jones was doing some documentation at that point, just some more clerical stuff while we waited, and I know Alyssa and I were in the nursery at that point just keeping an eye on things while we waited for them to show up.

Q. Dr. Jones was, wherever she was, she was in the nursery too, correct?

A. That's correct.

Q. You didn't make a note that day?

A. I did not.

Q. Why is that?

A. Normally, I would have. It was more of a timing issue than anything else. So from the time I got the call to the time I went down to assess the patient and then when Dr. Jones came in to take over, there wasn't a lot of time to run out and actually write a note.

I would have, had the timing worked out a little

differently, but at the time -- by the time she got there, the orders had already been placed. We made the decision to transfer, and at that point, she just did the documentation, so I figured while she was documenting, it was a better use of my time to stay with the patient as opposed to writing my own note.

Q. Okay. Did there come a point in time where Dr. Jones felt that this child needed to be intubated?

A. Yes.

Q. And were you there for the intubation?

A. I was.

Q. And did you in any way participate in that, or did she do that?

A. She did that mostly on her own. I think I maybe stood next to her and handed her things she needed. At that point, with the situation as critical as it was, I stayed out of the way and let her handle it.

Q. Once the West Penn team arrived, did you then continue to participate in the care, or did you leave at that point?

A. At that point actually, there were -- Dr. Jones was there taking care of -- the transport team was also helping her, and there were some things on the floor that needed to be done, so we both agreed that the transport team is here, why don't you go to the floor and take care of anything else that needed to be done, and at that point, it was the last interaction I had

with that particular case.
Q. And did you hear at any time that afternoon about what happened?
A. Yeah. Dr. Jones called me after lunchtime sometime just to tell me that the patient had passed. I didn't really get any specifics on how it transpired or what transpired or any discussion on what may have happened. It was more just a notification since I had been involved in the morning with it.
Q. Did you get the impression from talking to Dr. Jones at that time that she knew what had happened?
A. I did not at that point, no.
Q. You didn't get any impression as to whether she knew what had happened?
A. No. We didn't really get into it. It was more just an FYI, this is what happened.
Q. At some point after that, did you learn what happened, what had caused this baby's death?
A. I did. I don't remember. It was a while after, and I don't remember the exact interaction I had. I believe it was from Dr. Jones, but I think it was in passing. Maybe even several months down the line, I just asked, hey, do you know what happened with that, and at that point, she told me the official diagnosis, but that was the extent of the discussion at that point.
Q. Did you understand that the official diagnosis was that

she had an E. coli sepsis?

MR. PRICE: I have to object, Your Honor. She is just leading. She is just putting words --

THE COURT: There is a lot of leading going on.

Q. Did you ever learn what the official diagnosis was?

A. Yeah, I did.

Q. What were you told?

A. I was told it was E. coli sepsis at that point.

MS. KOCZAN: Thank you. That's all I have.

THE COURT: Any additional questions, Mr. Price?

MR. PRICE: Yes.

REDIRECT EXAMINATION

BY MR. PRICE:

Q. Dr. Heiple, I just want this jury to understand. You just testified all about your whole examination and your whole assessment of Kendall, and there's not one note in that binder, which are all the medical records, where you documented any of this, correct?

A. That's correct.

Q. Now, you have a very specific recollection about looking in the nose, hearing the heart, doing all of that on your assessment of Kendall, correct?

A. That's correct.

Q. Now, here is my problem. You remember whenever we first met, it was a couple years ago, and whenever you came into the

conference room at the hospital, I was there. There was a court reporter there.

A. Right.

Q. And your attorney was there, correct?

A. Correct.

Q. And before we started this question-answer session called a deposition, you raised your hand and you said I agree to tell the truth, correct?

A. Correct.

Q. And then whenever you came in here today, you raised your hand and you said I'm going to take the same oath, correct?

A. Correct.

Q. Now, if you could pull up page 8 of Dr. Heiple's deposition, because these are the words that you told me, and if you could just blow up this paragraph here.

And I already said this to you, but starting from the beginning, so we got called around 8:00, I just remember we were leaving our lecture hour, which ended at 8:00, and I got a call on my pager from the nursery just saying, hey, we have this baby.

Now, that's what you told me in 2017, and today, what you just told your counsel was that the lecture, you think, ended early?

A. I don't think I said that it ended early. I said it could have. I mean, at the time that -- if I may, at the time that

I gave the deposition, that was my recollection. Outside of this context, if you asked me what time are you called, I probably would have said the same thing today.

Q. Here's my point. My point is there has to be some reason why you have a motivation to change the time when you were so certain that it's 8:00 on the -- at the lecture hour.

MS. KOCZAN: Objection to the form of the question.

THE COURT: Sustained.

Q. Now, you also understand that with regard to -- you can take that down.

I already played for you the clips. Just so I understand, to be clear, to make sure the record is clear, before 8:00 a.m., you did not have any participation in Kendall's care; is that correct?

A. That's what I said, correct.

Q. You are saying today, that might not be correct?

A. Well, that was my best recollection at the time. I wasn't trying to intentionally mislead, but again, the deposition was two and a half years down the line. 20 minutes here, 20 minutes there. I couldn't say for sure.

Q. And now we are another two years down the line, and now you have a recollection -- you have a better recollection of this time two years after the deposition?

A. I wouldn't say that. I just think, again, there's room for error in terms of the exact time that I received the call.

Q. You were asked the question about what did Dr. Jones say whenever she came in and if you talked. I'm going to play you the clip from Jamie McCrory's deposition, JM067.

(Video played.)

BY MR. PRICE:

Q. Does that refresh your recollection as to what Dr. Jones had to say?

A. Potentially. It went something along those lines. I don't know the exact wording.

Q. So when she said why wasn't I called about these, do you remember her being that adamant about it?

A. I remember she wasn't happy about it.

MR. PRICE: That's all the questions I have.

THE COURT: Mr. Colville, anything at this time?

MR. COLVILLE: Just one question.

RECROSS-EXAMINATION

BY MR. COLVILLE:

Q. Dr. Heiple, have you reviewed the medical record at any time subsequent?

A. I have.

Q. The medical record makes reference to meconium and the references to the meconium, it has been described as thin to moderate, green colored liquid, nonparticulate?

A. Okay.

Q. My question of you is: Beginning with your involvement

when you came down to the nursery through the time you left to go on to the floor, did you see or hear anything that contradicts that description?

A. I didn't see anything to the contrary. To be honest, I don't remember hearing a lot or anything about meconium throughout it. I may not just be remembering.

MR. COLVILLE: Thank you.

THE COURT: Ms. Koczan, anything else?

MS. KOCZAN: One question.

RECROSS-EXAMINATION

BY MS. KOCZAN:

Q. You talked about your assessment that day, and you've given us some detail about that. Why is it that you remember this?

A. And it was a particularly unique, and obviously not in a good way, case that tends to stick out in your memory.

MS. KOCZAN: Thank you.

THE COURT: Doctor, I have a couple of questions.

You had indicated that when you were called from the lecture hall, you and Ms. -- now Dr. McKenna both went to the nursery, right?

THE WITNESS: That's correct.

THE COURT: And you did the assessment; is that correct?

THE WITNESS: That's correct.

THE COURT: And as you did the assessment, was she participatory to the assessment?

THE WITNESS: I think she was just standing next to me.

THE COURT: Did you have any discussion as to what your findings were?

THE WITNESS: Not with her, no.

THE COURT: Do you recall her saying anything about the baby?

THE WITNESS: I don't recall, no.

THE COURT: Vis-a-vis this residency program, you would have spent -- altogether, this would have been into part three month of your pediatric rotation, right?

THE WITNESS: That's correct.

THE COURT: And as a family practice resident, would you also rotate in OB?

THE WITNESS: That's correct.

THE COURT: And did you do that at Heritage Valley, too?

THE WITNESS: I did.

THE COURT: When you did those rotations at Heritage Valley, did you also interact with Dr. Dumpe?

THE WITNESS: I did.

THE COURT: And his partner, Dr. Lauer?

THE WITNESS: Correct.

THE COURT: You are currently employed by Heritage Valley, right?

THE WITNESS: That's correct.

THE COURT: Any other questions?

MS. KOCZAN: Nothing, Your Honor.

MR. PRICE: No, Your Honor.

THE COURT: Then, Doctor, you may step down. Thank you for your appearance here today.

Is the doctor excused? Is he going to be called again?

MS. KOCZAN: Not from my perspective.

(Witness excused.)

THE COURT: It's time for our afternoon break, ladies and gentlemen of the jury, so let's take one. It's just about five to 3:00 so we'll resume on the record at about 3:10.

I bet you could quote to me my recess instructions, but bottom line, you can leave your binders behind, your notebooks behind. Mr. Galovich will escort you and we'll start again at 3:10.

(Jury excused.)

(Recess taken.)

(Jury present.)

THE COURT: Mr. Price, your next witness.

MR. PRICE: Your Honor, just for some housekeeping matters, I have the PowerPoints from Dr. Heiple's testimony.

THE COURT: Thank you. Mr. Galovich, as you know, you'll mark that as a demonstrative for the plaintiff.

MR. PRICE: The next witness will be Dr. James Kenkel.

THE CLERK: Sir, please step forward. Please state and spell your name for the record.

THE WITNESS: My name is James L. Kenkel, K-E-N-K-E-L.

(Witness sworn.)

THE COURT: Thank you, Mr. Galovich. Dr. Kenkel, watch your step getting up there. It's a little bit uneven. I see you brought your briefcase with you and a book. Now, before you get started, Mr. Price, as with the other experts, the court has a limiting instruction.

Ladies and gentlemen of the jury, you are now going to be hearing testimony from Dr. James Kenkel and included among that testimony will be opinions. Dr. Kenkel is a professor of economics at the University of Pittsburgh. He'll offer his opinions because of his knowledge, skill, experience, training and/or education in the field of economics and the reasons for these opinions.

Once again, in weighing his opinion testimony, you may consider not only his qualifications, the reasons for his opinions as well as the reliability of the information supporting those opinions and any other factors I'll

ultimately discuss with you in my final instructions for you to weigh the testimony of individual witnesses.

The opinions of Dr. Kenkel should receive whatever weight and credit, if any, you think appropriate given all the other evidence in this case. You may disregard his opinions entirely if you decide they are not based on sufficient knowledge, skill, experience, training or education.

You can also disregard his opinions if you conclude that the reasons given in support of these opinions are not sound, if you conclude the opinions are not supported by the facts shown by the evidence or if you think the opinions are outweighed by other evidence.

In deciding whether you do or don't accept the opinions of Dr. Kenkel, you can consider any bias that he might have, including bias that could arise from evidence that he has been or will be paid for reviewing this case.

With that, Mr. Price will begin his examination.

JAMES L. KENKEL, PH.D., a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PRICE:

Q. Can you please state your full name?

A. My name is James L. Kenkel, K-E-N-K-E-L.

Q. And what is your address?

A. I live at 807 Academy Place in Mt. Lebanon, Pennsylvania.

Q. And can you tell us what is your current occupation?
A. For 49 years, I was a professor in the economics and statistics departments at the University of Pittsburgh, and last August, I retired after 49 years. So now, basically the employment that I do is I do some consulting work such as what I'm doing today.
Q. Part of -- as I explained to the jury, having experts testify, we have to know about your educational background and your qualifications, so let's talk about your educational background.
Can you tell us where did you go to school, college, all that stuff?
A. I have a bachelor's degree in mathematics from Xavier University in Cincinnati, Ohio, in 1966; a master's degree in economics from Purdue University in Lafayette, Indiana, in 1968; and a Ph.D. in economics from Purdue University in 1969; and I had additional training at Princeton University, Princeton, New Jersey in 1971.
Q. And employment-wise, you just mentioned that you used to be a full-time faculty member in the economics department at the University of Pittsburgh and that was since when?
A. After I got my Ph.D., I was hired immediately at the University of Pittsburgh in September of 1969, and I was a full-time faculty member there continuously until August of 2018.

Q. That's 49 years?

A. Yes, sir.

Q. What were your duties as a professor at Pitt?

A. Every faculty member had duties that fall into three broad areas and we are all supposed to teach. So I taught every semester at both the undergraduate and the Ph.D. level.

We are all supposed to publish and do research, so I've published a book on risk in mortgage lending. I've published a book on mathematical economics that is used in Ph.D. departments. I published several undergraduate statistics books, the latest is called "Introductory Statistics For Management and Economics." That's been used at 50 to 100 universities across the country.

Along with the statistics books, there are, I think, 13 additional books that are teachers' manuals, student study guides, computer test banks, solution manuals, all kinds of things that go along with a big textbook, and I published articles in lots of different economics and statistics journals.

So we are all supposed to teach, we are all supposed to publish and do research, and the third thing we are supposed to do is provide various services to the department and university. Throughout the years, I've served as the director of the Ph.D. program in economics. I've served as the chairman of the department of economics for more than 20

years. I was on the board of directors of the Computer Research Institute at Pitt, and I've served on probably 100 different Ph.D. dissertation committees.

Q. And part of working in economics, you know, and math and all, there's different societies that you can be members of, and have you been a member of any of these professional societies?

A. I'm a member of the American Economic Association, the Pennsylvania Economic Association, Mathematics Association of America, the American Statistical Association.

What I'm doing today is testifying in a legal matter. That area of economics is called forensic economics. I'm a member of the National Association of Forensic Economics. I'm a member of the -- let me see if I get it right -- American Association of Economic and Financial Experts, and I'm a member of the American Rehabilitation Economics Association.

Q. And part of that is, in cases, you learn about rehabilitation, wage loss, things of that nature, correct?

A. Yes.

Q. This is a pretty interesting fact I noted about you on your resume that, throughout teaching, you won certain awards. Can you tell us about that?

A. Yes. Well, I taught every semester to the Ph.D. students at Pitt, and in the 1980s, I think it was, they decided to have a teacher of the year award, and I was the first person

to get that award.

At the undergraduate level, I received a Teacher of the Year Award, and in the 19 -- late 1990s, I think, I was a finalist for the Most Distinguished Teaching Professor at the whole university, including the Greensburg campus, the Bradford campus and so on.

Q. In addition to working as an economics professor, during your work or during your life, did you perform any consulting services for governmental agencies or national corporations?

A. I have consulted with the Federal Home Loan Bank Board in Washington, D.C., concerning risk in mortgage lending.

I've consulted with the Environmental Protection Agency concerning proposed changes in pollution control laws and how it affects investment and profitability in the steel industry.

I've consulted with the Pharmaceutical Manufacturers Association of America concerning proposed changes in patent laws and how it influences development of new drugs and medicines.

Throughout the years, I've consulted with, I don't know, maybe 100 national and international corporations such as Dow Chemical, United States Steel, Ford, General Motors, Chrysler, Hyundai, Kawasaki, many, many others.

Q. Have you also taught seminar courses on how to calculate economic losses in cases like this where there's an injury or death?

A. Yes. I've done this since the early 1970s, and eventually, I was asked to give seminars to attorneys from Ohio, West Virginia and Pennsylvania who congregated at the University of Pittsburgh Law School, so I gave seminars to attorneys to show them what's involved in calculating economic losses.

I've been asked to give seminars before the Attorney General's Office for the State of Pennsylvania to explain to attorneys that represent the state what's involved.

I've given seminars before the Pennsylvania Bar Association, and I've discussed issues like this with numerous law firms around, western Pennsylvania.

Q. And when you talk about "issues like this," we're talking about the economic loss of Kendall Peronis?

A. Today, that's what I'm talking about, but what I was doing is explaining to attorneys all the things that are involved. I mean, if somebody like me gets a broken leg in a car wreck or you get killed in a car wreck, or in this case, we're talking about where the child dies and so on, there's different things that are involved in different cases, and another thing that's important is that the laws in different states are different, so how you calculate the loss is not the same, for example, in Ohio or West Virginia or Pennsylvania.

Q. Right. And approximately how many of these economic reports have you authored and how many times, you know, and

where have you testified?

A. I have probably written -- well, I know I've written more than 5,000 economic reports. Most of the time, cases settle, so you don't have to testify in court, but I've testified more than 500 times in situations like this.

I've testified in state and federal courts all over Pennsylvania, in Ohio, in West Virginia, South Carolina, North Carolina, Virginia, Maryland, Washington, D.C., New Jersey, New York, Connecticut, and I've testified in cases that were venued in Arizona and Illinois, Texas, et cetera.

Q. Okay.

MR. PRICE: At this time, Your Honor, I offer Dr. Kenkel as an expert in economics.

THE COURT: Any cross-examination on his qualifications, Mr. Colville?

MR. COLVILLE: Just a couple questions.

CROSS-EXAMINATION EN VOIR DIRE

BY MR. COLVILLE:

Q. Good afternoon, Dr. Kenkel.

A. Good afternoon.

Q. My name is Michael Colville. I represent the United States in this case.

When you were not retired, when you were actually working, what percentage of the work you are doing today accounted for your income at that point?

A. Maybe 15, 20 percent.
Q. Have you ever testified for Mr. Price's law firm before?
A. Yes.
Q. How many occasions?
A. I would say I've testified in court, I don't know, maybe five or ten times.
Q. When was the last time you testified for them?
A. I think two years ago.
Q. Have you prepared reports on their client's behalf where you didn't testify as well?
A. Yes, sir.
Q. How many of those types of reports?
A. I would say over the years, maybe 20 or 30.

MR. COLVILLE: Thank you.

THE COURT: Ms. Koczan, any questions?

MS. KOCZAN: None at this time. Thank you.

THE COURT: Anything further, Mr. Price, on qualifications?

MR. PRICE: No, Your Honor.

THE COURT: And Dr. Kenkel, having been offered as an expert in the field of economics and economic calculations, the court accepts him as same.

DIRECT EXAMINATION (Resumed.)

BY MR. PRICE:

Q. Doctor, at my request, did you prepare an economic report

projecting the economic losses in this case?
A. Yes.
Q. First, before we get into the economic losses, why don't you explain to us what is meant by an economic loss in a case like this?
A. Well, we can start out with suppose I was a 30-year-old professor at Pitt and I got run over by a drunk driver, whatever. The question would be what is the economic loss.

The one thing we would do is look historically at my income, and you would say what do you think his income is going to be in the future, so that's lost income.

The next thing you do is you would say, well, if he was employed at Pitt, they have a big fringe benefit package, they contribute to your retirement funds, they contribute to health care, dental, vision, et cetera. That's been lost, so what's the value of that.

So you want to look at your income stream. You want to look at potential fringe benefits. Suppose it's a 30-year-old man, I was married and had a couple kids, so I did lots of things around the house. I did grocery shopping and cleaned the cars, took care of the cars, maybe blacktopped the driveway and so on, so another area of economic loss in most cases is the value of household services. What are the things that you used to do around the house that helped other people.

And then in Pennsylvania, the last thing we have to do is

say, out of that income that you were earning, how much of it did you spend on yourself. We subtract that out because the rest of the income is then left for other family members.

So in this case here, we have a child that was -- died basically at childbirth so we don't have an income record to look at, so what we do is we go to the census and say how much do women earn on the average if you have, say, a high school degree, if you have, say, some college but didn't finish college, or what if you have a college degree.

So we don't have an income record because the child was never employed so we look at historical data from the census that says how much do women actually work or how much they actually earn based on their level of education.

The next thing we do is we can go to data that are published by different economics firms that say, well, how long do women work, so I have data that show the average or the median, the middle age at retirement for women, and typically, the women retire around age 62 or so on, so I have data in my report from the census that shows, say, when you are 25, how much do women make when they are high school graduates, when they are 30, how much do they make, when they are 35, how much do they make. The same thing for college graduates, et cetera.

Then I have data that says if you have a high school degree, on the average, how long do you work? If you have a

college degree, on the average, how long do you work?

Then I refer to data published by the Labor Department and the Department of Commerce. She is not employed. I mean, if I was injured at Pitt, you could go to Pitt and say what fringe benefits did James Kenkel get and how much did it cost.

Well, we don't have anything like that. So what we have are data published by the government that says, on the average, fringe benefits amount to about 27 percent of your wage income.

You think of the employers' mandatory contribution to Social Security and Medicare, that's 7.65 percent. Employers typically contribute to retirement funds, 401(k)s, pension plans, so forth, that's three to five percent of your income. Employers typically contribute to your health plan, et cetera, much more than that. The data show that on the average, the fringe benefits amount to about 27 percent, so I'll make a calculation of that.

The next area is the household services. In this case, I totally ignored it, and I think, well, my mother died at age 90 and my brother, my sister and I helped her around the house for years and years and years. So you would expect that this child, as the child got older, would eventually be helping the mother and father, but in this case, I've said I'm not going to make any calculation for household services.

Then the last area in Pennsylvania, we are required to

make a subtraction for what's called personal maintenance expenses. What we have to do is look at the total income that the person potentially could have earned and then say what do we think that person would have spent on themselves for certain mandatory items such as food, clothing, housing, medical care, some reasonable recreation.

So I have referred -- I brought along a document here. This is the consumer expenditure survey. This is from 2002 and 3, but they stopped publishing all the data as a book, but I brought this along to show you what we have here, and in here, we have hundreds of different tables showing how much money people spend on food, clothing, housing, medical care, recreation, et cetera, based on what your income is.

Clearly, if your income is $20,000, you are going to spend a different amount on food and housing than if your income is $100,000. We have data, what if you are single, what if you are married, what if you are married and working and have a couple kids, et cetera, so the amount you spend on yourself varies depending on your lifestyle and your family situation.

So what I've done in this case is I treated Kendall Peronis as a single person, which would mean that she is going to spend the maximum amount on herself.

If you are married, if the family income is a certain amount, some of the money is going to go and be spent on the husband or on the wife. Some of the money is going to be

spent on the kids, and the housing expenses would continue, so you could say you don't need to subtract housing. In this case, I'm making a subtraction for all these things.

Q. Okay. Of course, in this case, since you are going to be making projections of economic loss for Kendall from her birth through her expected lifetime, correct?

A. Yes.

Q. And again, there are -- I know you brought a lot of books with you, but there's life tables and things like that which have the average. You can take a look at if a child is born today and take a look at that to determine how long that child would live?

A. Well, I brought along here what is called the United States Life Tables. New ones are published just about every year. In here -- this is just a portion of the big document, but what we have here is data that show how long you can be expected to live based on how old you are today and whether you are male or female, white or nonwhite.

So what we have is at childbirth, a person like Kendall Peronis would be expected to live for 81.4 years. Some people live longer and some people live less, but most people live a heck of a long time.

There's also data in here that show what percentage of people -- for example, I'm going to say she had the potential to work to, say, age 62 or more. What percentage of people

actually live to age 62. Well, if you are a young baby girl, 90 percent of baby girls live to at least age 62. 83 live to at least age 70. So it's not like oh, 50 percent of kids die at age seven or eight, whatever. Most people live a heck of a long time.

The next thing that we need is when is she going to retire, so this is the part of the article that shows how old the women are when they typically retire, and the data show that if you start working at age 18 with a high school diploma, on the average, you work about 43.9 years. If you start working at age 20 with some college, you work for about 43.8 years, and if you start working at age 22 with a college degree, you work for about 42.7 years.

So I'm not making the numbers up. I've got the documents here that support all this.

Q. These are all -- even though our lives are boiled down to numbers, the government keeps all of these statistics about what the average is for all Americans, and that's what you used to calculate an economic loss?

A. In this case, I based my report on white females.

Q. Right. So did you receive background information from us necessary to project the economic loss for Kendall?

A. Yes. I mean, I know she died basically at childbirth so she's got a life expectancy of a little over 81 years.

We can expect if she worked until the typical age at

retirement, based on her education, she worked, give or take a little bit, about 43 years.

I had some information about her parents. Her father Matthew was born in 1994. What I wrote in my report, he was 23 or so. I guess now, he's a little over 24. He has a life expectancy to age 78, so he's expected to live 53 or 54 additional years. He graduated from high school in 2013 and he's been working in construction at the Shell Oil Cracker Plant in Beaver, so he's employed full-time.

The mother Carissa was born also in 1994 so she would now be about age 24. As a woman, her life expectancy is slightly larger than for a man, so her current life expectancy would be about 58 additional years to about age 82. She also graduated from high school. What I wrote in my report, she was attending the Police Academy, and I've been informed that she has graduated from the Police Academy and was studying criminal justice and police technology at the Community College of Beaver County, so she also, besides the high school degree, had some college.

She has worked at various different places and she is now working in the restaurant business, but she recently told me, I think she wants to get into the police work based on her education and so on, so I have some information about the family background, but then typically in cases like this, what we do is refer to census data to ask on the average how much

do women make based on their level of education.
Q. Just for the jury's understanding, while the parents, their educational background and their educational attainment and how long they are going to live is good historical data, just because your parents only graduated from high school doesn't mean, especially in America, that you can't go to college or do something different.
A. Well, I have data in my report that show what percentage of people graduate from high school, and now that's way over 90 percent, and I have data that show what percentage of people attend college.

Now, for example, when I was in college in 19 -- in the 1960s, only 11 percent were attending college. Now it's over 40 percent, and every single year, the percentage has gone up.

Another example, I mean, my father had to drop out of high school because his father had died so he had to take care of my mother. He dropped out of high school after his freshman year. I have a Ph.D. My brother has a master's degree in engineering. My sister graduated from high school and was executive secretary for executives at Procter & Gamble, so we far exceeded the education levels of our parents, which is really pretty common nowadays.

I wouldn't expect my kids to exceed my level of education because I'm pretty much at the top of the pecking order, but my daughter has a master's degree, my son has a college degree

in economics and has passed various stock licenses, et cetera, like as a stockbroker, so their education levels are much better than, say, my parents' education levels.

Q. So after you collect all that data and you learn a little bit about the family, you then calculate a wage loss, and can you just explain to us -- I know in this case we have some tables we'll show the jury in a second, but you calculated wage loss in three different ways, correct?

A. Yes. I projected potential wages as a high school graduate, potential wages with some college and potential wages as a college graduate.

Q. So as we put this up as to lost income, fringe benefits, you can explain how that all works, so why don't I put up on the screen the first page, and this will be table 1, and this is your economic projection or net economic loss for a high school graduate who had a work life of 43.9 years.

First, you have above your calculations a note that all values are discounted to present value, and again, that's another economic term.

Can you tell us what that means and why you did that?

A. All right. What we're doing is talking about the projected loss in the future. If the jury decided that the defense was liable, you would have to set aside a certain amount of money today so that money could be invested and it would grow to match the future losses that I have -- I'm going

to project.

So as an example that might clear your mind and might make it a little bit simpler, suppose you had a child that was in the seventh or eighth grade and you said I want to set aside some money today for that kid's first year in college, five years from now. How would you decide how much to set aside?

Well, the first thing you would do is you look at some data and say how much does college education cost today? That's what we're going to do in this case. How much could this girl have earned once she is 18.

Suppose the college education today costs $20,000, then you have to say, well, let's look at historical data and inflation rates and so on and see how that tuition, that cost of college has increased over time, because in five years, it's not going to be 20,000, it's going to be more than that.

So let's say it's going to be 25,000, so we say here's how much it cost today. How much is it going to cost in the future? We're going to do the same thing with the college education, et cetera.

The next thing then is once you decided, wait a minute, I'm going to need, say, $25,000 five years from now, if I put money into a certificate of deposit today and got a fixed interest rate, how much would I have to put into that pot today. If the interest rate is high, you wouldn't have to put in so much because it's going to grow rapidly, but if the

interest rate is low, which interest rates are today, you are going to have to put a lot of money into that pot so that it can grow to $25,000.

So the amount that you would have to put into the pot today so that it would grow to 25,000, that is called the present value. We're going to do the same thing with the income.

So what I'm going to do, I have in my report here is how much 18-year-old girls make in 2016 when they have a high school degree. Here's how much 30-year-old girls make. Here's how much 40-year-old girls make and the money goes up each year because you've got more experience, more seniority, more knowledge, et cetera.

So I started her out at exactly the incomes that white females were actually earning, and then I looked at government data and said what do economists, what does the Congressional Budget Office, what does the Social Security Administration, what do blue chip investors, what do the forecasters say is going to happen to inflation.

They typically said the inflation rate, 2.3 percent was their low estimate, which is what I've used, so I've said if a female could earn say $36,000 at age 35, I'd say, well, she is going to be 35, 35 years in the future. That amount is going to grow at 2.3 percent per year, so it might grow to $60,000, so I'm going to say, 35 years from now when the child would

have been age 35, she should be making like $60,000.

Then the question is, if you put money into the savings account today and let it sit there for 35 years at current interest rates, how much would you have to put in there, and the answer might be something like $28,000.

To make it clearer, when I got hired at the University of Pittsburgh 49, 50 years ago, my salary was $11,000. Right now the minimum wage is like $16,000 and the people raise the minimum wage to $15 an hour, you work 40 hours a week, that's $30,000 a year. So when I say, the income that's 35,000 today might be 60,000 in the future, that's really reasonable.

Q. Now, I did not bring -- want to put your whole report up, but can you pull up your report to show the jury a lot of these different tables that you --

A. Here is the data that shows, for example, in 1995, when you are 18, the girl with a high school degree makes $13,999. In 2016, the same girl at age 18 is making 24,278. I've got how much you make at any given age, I've got the data. I mean, I've got data at home back to 1980 but only fits to 1995. Every single year, the income goes up.

Q. So with all of that, the first line that you have is lost income for a high school graduate for Kendall, over her lifetime would earn $1,207,494.

Can you tell us where does that number come from? Is that what you just told us, all of that?

A. What I did was I said I'll start with the actual earnings of actual white females in 2016 and I'm going to increase those numbers 2.3 percent every year, which is what the economists projected for inflation, and then I went to the Treasury Department and found out what are actual interest rates.

If you are going to try to invest money for one year, what's the interest rate? If you are going to invest money for five years, what's the interest rate? I used the actual interest rates and brought everything back to present value.

Think about if you worked for 40 years and made $40,000 a year, that's 1.6 million. I've got her working for 43 years but in present value, it's $1,207,494.

Q. Because that seems like a big number, but over a lifetime, it's not as much as you think?

A. I just think it's reasonable. Whether you think it's a big number or small number, it's what it is.

Q. Now, lost fringe benefits, and you briefly talked about that, that would be the health care, that would be the Social Security, that would be the other fringe benefits, and you calculated that based upon the average that employers pay throughout the United States?

A. Yes. That's 27 percent.

Q. That would be 27 percent of your 1.207?

A. Yes.

Q. That equals 326,023. You mentioned you did not add in lost household services. For example, as you mentioned, if I'm injured and I can't cut my grass, I have to pay somebody or I can't do something, I have to pay somebody. That's a household service that I have to pay for.

There's an economic value for me not having to pay somebody. Is that a bad way of putting it?

A. Well, in this case, what I'm saying is if Kendall were still alive, over the rest of her lifetime, she would do lots of things for her parents. I mean, kids, you go to the store, you cut the grass, you clean the windows. When your parents get old, you take care of them.

What I'm saying, this child over their lifetime would do things for their parents, but I'm ignoring that.

Q. Okay. You have to take out what you mentioned was personal maintenance, and that is the clothes, food, house, rent, things of that nature, correct?

A. Yes.

Q. And again, this is based on governmental statistics?

A. Yes, from the Consumer Expenditure Survey.

Q. And that was $736,571. So the net economic loss that you projected for a high school graduate of Kendall's age at birth would total $796,946?

A. Yes.

Q. Now, if we go to the next table, and this would be table

2, and in this one, you changed it a little bit, and you projected that the economic loss would be for somebody who had gone to a little bit of college.

Can you explain the difference in economic, I guess, benefit to a person who just has a high school degree as compared to has some college?

A. Well, the data just show that people that have some college, maybe it's one year, maybe it's two, maybe it's three, you went to college, that shows something, number one, that you want more education and it might be -- not necessarily, but it might be you are better intellectually than the kid that says I don't want to go to college or I'm afraid to go to college, so it shows something anyway that you have got some drive and ambition, but the data just show that kids that have some college on the average earn more than kids that don't have some college.

Q. So if Kendall had some college over her work life expectancy, her lost income would total $1,431,646?

A. Yes. That's in present value terms again.

Q. And then you reduced it by the lost fringe benefits of 27.5 percent?

A. I increased it by 27 percent.

Q. I'm sorry, 27 percent. For $386,544. And then you took out the personal maintenance of 744,456, and just so the jury understands, that number increased also, correct?

A. Yes.
Q. A person with some college over their lifetime would have more personal maintenance than a person just in high school?
A. Well, the amount you typically spend depends partly on your income. If somebody makes $20,000, how much they can spend is limited. If you make $100,000, you can spend a heck of a lot more, so typically the person that has a higher income spends more than the person that has the lower income.
Q. So some college work life expectancy net economic loss for Kendall would be $1,073,734?
A. Correct.
Q. And then the last calculation you made was for table 3, and this is if she -- it is if she had gone to college and was a college graduate, correct?
A. Yes.
Q. And we'll just refer to your report while we're waiting for it to come up on the screen. So the work life for a college graduate is only 42.7 years as compared to 43.94, somebody in high school, correct?
A. Yes.
Q. And that takes into consideration that they have to go to school a little bit longer, they might still work longer but they have to go to school?
A. Right.
Q. And then their lost income for a college graduate of

Kendall's age would have been $2,128,633?
A. That's right, yes.
Q. The lost fringe benefits of $574,731, correct?
A. Yes.
Q. And then you take out the personal maintenance, and that's $979,171 for a net economic loss for a college graduate of Kendall's age of $1.724,193, correct?
A. Yes.
Q. And those are the calculations that you prepared for us to explain the economic loss for Kendall in this case, correct?
A. Yes.
Q. Have the opinions you've expressed been to a reasonable degree of economic certainty?
A. Yes, sir.
MR. PRICE: That's all the questions I have, Your Honor.
THE COURT: Mr. Colville, any cross-examination?

CROSS-EXAMINATION

BY MR. COLVILLE:
Q. Good afternoon.
A. Hello.
Q. I went to the University of Pittsburgh back in '81-'85, and statistics, I remember them well.
The job you have is made more difficult because you don't have any factual background on Kendall because she died very

soon after her birth to have some type of base evidence to say here's what she would make looking out in the future like you would have if you retired 20 years ago?

A. If we had a secretary that was age 30 that had worked at the same place for five years or whatever, you would say let's look at that person's income and see how it's growing, et cetera, and you would have more certitude on what you are doing.

Q. The more information you have, probably the more accurate your report is going to be, at least as far as projecting into the future, right?

A. Yes, sir.

Q. Nobody has a crystal ball to say with any real certainty here's what this person is going to make from this point forward, whether it's from day one or 30 years into their career, right?

A. Yes, sir.

Q. But you would rather have someone who has 30 years' worth of career and evidence and facts to base your projections with?

A. That's correct.

Q. In this case, because you didn't have that, you are relying on the statistical averages --

A. That's correct.

Q. -- that are in the books and the government statistics

that the census brings together; is that right?
A. That's correct.
Q. You are using life expectancy statistics, work, life and education as the statistical average, right?
A. Yes, sir.
Q. And we can all agree that two people, three people, a thousand people all born today, if we were applying the statistical average that you would apply to all of them, odds are they would all have different incomes, different education outcomes, different work lives, correct?
A. Yes, sir.
Q. And if you had written a report for each one of them, they would -- your report would say the same thing for each one of them, right?
A. That's correct.
Q. Yet everybody would be different?
A. That's correct.
Q. And while some might be exactly spot on average, odds are most of them wouldn't be, correct?
A. That's correct.
Q. And in that situation or that scenario, your report would be either underestimating or overestimating but it wouldn't be accurate as to those people who were not the statistical average; is that right?
A. Depends on what you mean by accurate. It is the best

projection. I would say that it's not going to be exactly correct on what they actually earn.

Q. Please don't take offense. I'm not being pejorative about it. I'm trying to conceptualize what you are doing is you are saying I'm going to treat everybody born today as statistically average looking forward, at least as I project what they are going to do income, wage, or work life, and that's probably just not going to happen on a statistical average for everybody born today. Some will, but most won't.

Do you agree with that?

A. Yes.

Q. With regard to the assumptions as to whether somebody goes to high school or graduates high school, graduates some college or graduates college, there's a lot of factors that go into it, and the same type of variability occurs if you look at all the people born today.

Some people's parents have more money than others and can afford it. Some people have parents who both graduated college and they're more likely to graduate high school and go on to college. There's thousands of other variables that impact that ability. Would you agree with that?

A. To a certain extent, yes, except the data show that, I mean, virtually everybody graduates from high school. So if you say are there thousands of factors that influence that, I would say main factor is did you live to be age 18 or 19,

because more than 90 percent of white females graduate from high school, and at the present time, about 40 percent or more are graduating from college.

Q. Nobody is disagreeing with that, but there are still ten percent who don't graduate high school, right?

A. Yes.

Q. And your report doesn't reflect that, and I'm not suggesting it should, but it just doesn't?

A. That's correct.

Q. If Kendall happened to be one of those persons who didn't graduate high school for whatever reason, your report doesn't accurately reflect that projection looking forward. That's all.

A. That's correct, but I did emphasize that more than 90 percent do graduate from high school, so that's by far the most likely scenario.

Q. Again, agreed and understood. There is a footnote in your report that does indicate that whether or not somebody graduates high school or wherever the educational chain that person finds is influenced by what the parents have accomplished in their educational pursuits; is that right?

A. Yes, sir.

Q. In this case, it's sort of a mixed bag. Matthew has only graduated high school, he hasn't graduated some college or college at all, and Carissa graduated high school and has not

graduated community college yet and has the Police Academy but has not completed college.

So to the extent you are suggesting in that footnote that whether or not you graduate high school or some college or the college is dependent upon the parents' educational background, we don't know, and you can't predict based upon the parents involved in this case where Kendall would have fallen, correct?

A. Well, we can predict. We can always forecast and predict, but I don't know with certainty, no.

Q. Your prediction is only based upon the statistical average, again assuming she is one of a thousand people that are all predicted by you to meet the statistical average when we know not everybody will, correct?

A. Yes, sir.

Q. The incomes that you assign for a high school graduate or a graduate of some college or graduate of college, again, all is the statistical average of income earned by those groups, but you would agree that, within the group itself, high school graduates, they don't all earn the same amount of income. Some earn a lot; some earn a little; some are right in the middle, right?

A. Yes, sir.

Q. So the same thing applies in this case of the scenario with a thousand people, Kendall being one, assuming she would

have graduated high school or, for that matter, even some college or college, the amount you are attributing to her as earning an income is only a statistical average, but it doesn't account for the possibility that she may have fallen short like any other people that were born on the same date and same time; is that right?

A. It also doesn't take into account that instead of falling short, she could have greatly exceeded the averages.

Q. Understood and agreed. In this case, one of the projections is that she would have graduated college. I don't see anything in your report which accounts for the cost of college.

A. That's not part of the legal scenario.

Q. Well, okay.

A. It's not part of personal maintenance so I'm not supposed to discuss that.

Q. Okay. I don't understand that. What I understood you were doing is you are saying here's all the income that would have been taken in by Kendall and here's the money that would go out and the number that we're giving to the jury is what's left over. You've assumed that she is going to be a single woman.

If she is a single woman and she is getting the college years, and she graduated high school and she's decided I'm going to go to college, it's not going to be for free likely.

It's going to cost some money. Would you agree with that?
A. Yes. It's also possible the parents are going to pay for it, but it's also not part of personal maintenance.
Q. But that cost has not been deducted?
A. That's correct.
Q. The work life expectation, you make a reference that it would be continuous work life. What does that mean? You anticipate she will work if she is a high school graduate 43.9 years work life and it will be continuous.
Do you mean there will be no breakage of that employment for 43.9 years?
A. In my report, I said she would work potentially to age 67, and of those years, she would work about 43 of them, so there's periods in between that she could be in or out of the labor force.
Q. I didn't understand that so I wanted to be clear. Your work life expectation doesn't account for the possibility that she would choose to have a child and raise that child as opposed to being in the workforce, does it?
A. That would change everything though, because if she is married and has a child, now she's got tremendous household services which could add up hundreds of thousands of dollars, also the personal maintenance -- I've subtracted over 60 to 70 percent for personal maintenance.
When a person is married and has children, the personal

maintenance deduction could be as low as like 15 to 20 percent.

Q. I'm not suggesting it wouldn't change the report. I'm just saying your report doesn't account for it. That's all.

A. I did not, no. The legal parameters that I understood is you take the person the way they were kind of at the date the trial.

Q. I don't even know. Women born today, what percentage of those women have children? It's pretty high, right? It's about half? Maybe a little more than half?

A. Could be.

Q. So that's a statistical bullet point that could have been used and could have been input here?

A. No. That's not the way the law treats people. I mean, I'm married. Right now, you don't say, well, what if you are not married. You take the person the way they are.

Q. The fringe benefits that you reference, explain to me how you did the calculation. How are you accounting --

A. You look at government data that says what percentage of income do firms add for fringe benefits. First of all, you've got the mandatory contribution of Social Security and Medicare.

Q. Let me stop you there.

THE COURT: Whoa, whoa. Let the witness get to the period, Mr. Colville. I know you are anxious to ask

questions.

Doctor, if you need to finish that last answer, please do it.

A. We take into account the mandatory contribution to Social Security and Medicare. We add in that almost all firms contribute to pensions, retirement, 401(k), health benefits, vision, dental, et cetera, and the average across the whole economy is about 27 percent of income.

Q. With regard to the Social Security, Medicare, wouldn't the recipient, in this case Kendall, have to pay a matching contribution that the employer would pay?

A. Yes.

Q. Did you account for that in this?

A. No. That's a tax. Under Pennsylvania law, we never discuss taxes.

Q. But that wouldn't be money coming out of her -- the money she earns in whatever job she had as a high school graduate, some college graduate or college graduate?

A. There's various expenses she would have that we don't discuss because it's not part of Pennsylvania law.

Q. Now, when you prepare a report, do you have a predisposition depending on who is asking you to prepare the report, the plaintiff's side or the defendant's side?

A. No.

Q. Are you more inclined to project more damages for a

plaintiff as opposed to a defendant?
A. No.
Q. Do you recall an expert report you prepared regarding an individual by the name of James Margo?
A. Yes.
Q. In that case, you prepared two expert reports regarding Mr. Margo in the same case; is that right?
A. Yes. I was given vastly different information which led to completely different reports.
Q. In that case, Mr. Margo was dead at the time you prepared the report?
A. Yes.
Q. He had been in jail; is that right?
A. Yes.
Q. And he had been in jail years before you prepared both reports; is that right?
A. Yes.
Q. Initially, you prepared a report for the plaintiff's firm. Do you remember that?
A. Yes.
Q. And that report was dated December 22nd, 2007, correct?
A. Yes.
Q. Now, in that report, you offered an opinion that, based upon a work life experience that you had projected, I'm assuming based upon the same statistical averages that you are

doing here today, you predict a work life expectancy of 21.5 or 21.7 years and an economic loss was 796,000 and 1.7 million?

A. That's based on information provided to me by the attorney which turned out to be completely wrong.

Q. Now, in that case --

A. That projection is useless because the background information was he's a high school graduate. No. He was kicked out of high school for fighting and dealing drugs.

MR. COLVILLE: Your Honor, I would move to strike as nonresponsive to the question I asked. I didn't ask a question. He's just testifying.

MR. PRICE: I object, Your Honor. He opened the door and he's explaining.

THE COURT: He did, yes. Motion denied. Explanation stands.

Q. You indicated --

MR. PRICE: Your Honor, may he finish his answer?

THE COURT: Yes, I would like him to finish the answer. I like all witnesses to finish answers. I'm sure our jurors do, too.

A. I was given information that this person had worked as an auto mechanic, as a roofer and as a construction worker. Auto mechanic, what we found out was between the age of 16 and 24, he had worked for less than two months out of the eight years.

He worked filling gas tanks at a gas station.

Construction worker, what he did was he helped his father dig some post holes to put in some fences at the family house.

As a roofer, he handed up some shingles to his father to put some shingles on the roof. I didn't know that.

I was informed that he had a career as an auto mechanic, as a construction worker and as a roofer, so I went to government data and said on average how much does a person like that make, and at the time, that was like $30,000 a year. Over 30 years that's $900,000. That's where my number came from.

Q. Okay.

A. A couple years later, the defense calls me and said we have a case about some guy you won't believe but he got kicked out of high school for dealing drugs, he stole money from his grandmother to buy more drugs, he had been incarcerated year after year for being a heroin dealer and he died in jail from an overdose.

The one person told me -- the plaintiff told me that the reason he was in jail was for a routine traffic stop. Actually, what happened was he was violating probation. He died in jail. I didn't know why he died in jail. I thought maybe the police beat him up or something. He died from an overdose of drugs. When he died, how much did he earn? Zero. He never had been employed.

So what I did, even I said maybe he'll clean his act up and work and make the minimum wage. If you make the minimum wage and we subtracted those expenses, you are down to zero, so in the one case when I was given totally wrong information, I said the loss is 900,000. I didn't know he was a drug dealer who constantly was in jail. I didn't know he got kicked out of high school. I didn't know he didn't work as an auto mechanic, et cetera.

On the other side when I was given the correct information, I said that plaintiff report is basically useless. I'm just trying to honest.

I'm not saying, if I'm on one side, I do one thing, and if I'm on the other side, I do something else. I just go with the information I'm given.

Q. Just so we are clear, the two reports you prepared were in the same lawsuit. It would be as though you prepared a report for Mr. Price and you prepared a report for me.

A. That's exactly right.

Q. Both of the reports that you prepared, you swore that they were within a reasonable degree of economic certainty?

A. Based on the information that I started with, that is exactly right.

MR. COLVILLE: That's all I have.

THE COURT: Ms. Koczan, any questions of this witness?

MS. KOCZAN: I do not, Your Honor.

THE COURT: Mr. Price, any follow-up?

MR. PRICE: Just a few.

REDIRECT EXAMINATION

BY MR. PRICE:

Q. I'm not going to follow up on that because you seem to have addressed that. I did not come to you and ask you to assume that Kendall was going to graduate from Harvard, go on to start her own web company, compete with Google and travel around the world making millions and millions of dollars for appearances at the MTV awards or something like that, did I?

A. No. I was given -- what I do is I start with an information form, and I say you want me to do an economic report, provide this information to me, and I assume that the information that is given is correct because I put most of it into my report, so if you would have told me, oh, Kendall died at age 24 and she had a Ph.D., I would have used that, and you'd say that's not true. She died at age zero and didn't have a Ph.D. I'd say if I didn't know that, my report would be worthless.

I have in here all the information that I discussed, the education of the parents, the names of the parents, the date of birth, education background, et cetera.

Q. And in this case --

THE COURT: For the record, the witness is showing

the jury the form he uses.

Go ahead, Mr. Price.

Q. In this case, we just simply asked you to do the median, the average girl who would go to high school, college and some college, correct?

A. Actually, they didn't ask me that. They said provide an estimate of the economic damages, so everything else is my opinion. They didn't say assume she is going to make the average of a high school graduate or whatever. I did that. They just said project the economic damages.

Q. Good point.

MR. PRICE: That's all the questions I have.

THE COURT: Thank you, Mr. Price.

Anything else? Mr. Colville? Ms. Koczan?

MR. COLVILLE: No, Your Honor.

THE COURT: Doctor, you may step down. Thank you for your appearance here today. I believe the doctor may also be excused.

(Witness excused.)

THE COURT: You did have a briefcase. Make sure you take it.

Mr. Price, are you prepared for another witness?

MR. PRICE: First, just for purposes of the record, to introduce the tables that were shown up on the screen.

THE COURT: You have some additional exhibits. Any

objection? He projected the economic loss on the screen. He just provided hard copies to Mr. Galovich. Any objection?

MS. KOCZAN: Are these exhibits or are they demonstratives? Are you introducing them as exhibits?

MR. PRICE: No. I'm introducing them because they are part of the record.

MS. KOCZAN: I don't have any objection to it.

THE COURT: Mr. Colville?

MR. COLVILLE: No objection.

THE CLERK: Plaintiff Kenkel demo.

THE COURT: Yes. Anything else, Mr. Price?

MR. PRICE: No. My next witness would be Matthew Fritzius. I'm just looking at 4:15. Do you want me to start?

THE COURT: Well, it's up to you. Mr. Fritzius is here.

MR. PRICE: He is.

THE COURT: Do any of you jurors have an engagement or something this evening that you can't stay? Anybody need to leave earlier than quarter to 5:00 or so?

A JUROR: Will we still make the bus?

THE COURT: What time is your bus?

A JUROR: I get the bus at 5:00 or ten after at the latest.

THE COURT: I was just talking to staying until about quarter to 5:00. Would it be better?

A JUROR: I can do quarter to 5:00 so I can run out.

THE COURT: Right. We will not go any further past quarter to 5:00. Does that work for everybody?

So Mr. Price, do you want to start Mr. Fritzius at this time or did you want to demo those pictures that we talked about earlier?

MR. PRICE: I'm sorry. If I wanted to --

THE COURT: Demonstrate the pictures that you entered into evidence earlier. At one point, you indicated you were going to pass those to the jurors.

MR. PRICE: Yes. I'm sorry, Your Honor. I seem to have lost my notes for Matthew -- here they are.

Your Honor, for purposes of the record, I have original photographs of Exhibits 29, 30, 31, 33 and 34. These photographs are contained within the -- in the joint exhibit list, in the exhibit binder, there are blowup pictures that are pixilated, and these are the actual pictures from the camera, so I think they are a little clearer and they are a little bit more detailed, so I ask to introduce them, the originals for the jury.

THE COURT: Right. There was no objection by the defendants, and given the nature of the pictures, what the court normally does is have the pictures passed. Mr. Galovich will assist.

THE CLERK: For clarity, Your Honor, this isn't being

readmitted again.

THE COURT: No. They've already been agreed upon and admitted, but we did not have an opportunity to have the jurors take a look at them.

So let the record reflect that the pictures that were just referenced as exhibits are now being passed to our jurors one by one.

It appears that all of our jurors have had an opportunity to review those exhibits. The originals have now been returned to Mr. Galovich.

As I indicated to you earlier, Mr. Price, when the jury goes out to deliberate, then they should also have the opportunity to have those pictures go with them. Mr. Galovich is done taking custody and I think you already have those logged in; is that correct, Mr. Galovich?

THE CLERK: Well, they are not logged in separately, but they are logged in as joint exhibits. I will put them in the binder.

THE COURT: Thank you. Now, it's about 4:25. Is there any other "housekeeping" before we call another witness?

MR. PRICE: No, Your Honor.

THE COURT: Would you like to start with Mr. Fritzius?

MR. PRICE: Yes.

THE CLERK: Please step forward. Please state and

spell your name for the record.

THE WITNESS: Matthew Fritzius, F-R-I-T-Z-I-U-S.

(Witness sworn.)

THE COURT: Mr. Fritzius, please watch your step. It's a little uneven there. Mr. Price, you may proceed.

MR. PRICE: Thank you.

MATTHEW FRITZIUS, a witness herein, having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. PRICE:

Q. Matthew, you have to pull a little closer to your mouth but speak into it. Okay.

A. Sound good?

Q. Perfect. Can you please tell us -- we know your name. Where do you live?

A. I live in Monaca in Beaver County.

Q. And you are a plaintiff in this matter?

A. Yes, I am.

Q. And you are the father of Kendall?

A. Yes, I am.

Q. You have filed this lawsuit on behalf of the estate along with Carissa?

A. Yes.

Q. Before we get into the facts of the case. Tell us a little bit about yourself. Where were you born?

A. I imagine I was born in Beaver County. I don't know all the details on it, but born in 1994, September 11 was my birthday, and I was just born and raised in Beaver County.

Q. Any brothers and sisters?

A. Yes, actually. My dad has six children total. My mother has four, so I have three brothers and two sisters.

Q. And grew up in the Beaver County area?

A. Yeah, born and raised.

Q. And schooling, did you go to school in Beaver County?

A. Yeah, I spent time in Beaver Falls, and I graduated from New Brighton.

Q. Now, from what I understand, at some point, you left Beaver Falls and went to New Brighton?

A. Yes. I left the Beaver Falls School in like seventh grade, and then I moved over to New Brighton at the end of the school year over there.

Q. From what I understand, at some point whenever you moved over to New Brighton, you met somebody in your home room?

A. Yes. That would be Carissa.

Q. Tell us a little bit about meeting Carissa.

A. Well, it was -- I mean, to look back on it now, it was definitely interesting. She was very pretty to me, and I thought I was quite charming, to say the least, so I would, you know, I would definitely engage in conversation with her and try to get to know her.

Q. And did you start to get to know her?
A. Yes. It was the next year in our eighth grade year is when we became official like boyfriend and girlfriend.
Q. So in grade school, you are official boyfriend/girlfriend and everybody in the school knows that?
A. Yes.
Q. Did you continue to hang out? Too early to drive, so were you dating?
A. Yeah, we were dating, but luckily, New Brighton, it's like a smaller town in the county, and there's a lot of things in walking distance. You know, we have a nice park, restaurants and whatnot, so we spent a lot of time just out in the streets with our friends playing release and things like that.
Q. Did you two stay together as a couple through high school?
A. Yeah. All through high school we were together.
Q. After high school -- what year did you graduate from high school?
A. 2013 we graduated.
Q. And after that, did you have any plans for your future?
A. My future was just focused on work, just go straight into the workforce and try to make as much money as I could.
Q. Did you start working directly after school?
A. Yes, directly after school.
Q. What did you do?
A. I started off in the shoe department. It wasn't much. It

was pretty much my first job. I was in a restaurant for a year, but then I got into this -- a company called Phoenix Glass Anchor Hocking. It was located in Monaca, PA, basic labor.

Q. Anchor Hocking is a bigger corporation in Beaver County?

A. Yes.

Q. What do they make?

A. Glass products.

Q. From what I understand, at the time Carissa was pregnant with Kendall, you were working there?

A. Yes. By the time we had Kendall on the way, I would have been there about a year and a half.

Q. What did you do there?

A. Basic labor. Like they have lehrs, I don't know if you guys know what lehrs are. Just big belts that a bunch of glass comes out on, and we were required to put the glass into boxes, ship the boxes up, pack them up, tape them, get them out where they got to go.

Q. And from what I understand, it's a 24-hour operation?

A. Yes, 24/7, yeah.

Q. Did you have a specific shift or when would you work?

A. They rotated shifts. So we would be on 7:00 to 3:00 one week, and 3:00 to 11:00 the next week and 11:00 to 7:00, so on and so forth.

Q. Did you work weekends?

A. Yes.
Q. After you graduated from high school, did you and Carissa continue on as a couple?
A. Yes, we did.
Q. And at some point, did you and Carissa move in together?
A. Yes, we did.
Q. And was this before she became pregnant?
A. This was well before she became pregnant.
Q. Whenever you two were living together, was she working?
A. Yes, she was working.
Q. Where?
A. It was a restaurant. I believe at the time, it was called Water's Edge.
Q. And at some point, she comes and she tells you that she is pregnant?
A. Yes. At this point, I was helping -- my friend worked at a restaurant called Pigs 2 Peaches, a barbecue restaurant. Some days I would help them out. Just lovely people I loved to work with.

We were closing for the night and I received a text message that we need to talk, and any time you hear those words, you know, the only thing lingering in the back of my mind is like what did I do wrong, but I come to find out for her to tell me that we had a baby girl coming on the way.
Q. And how did that make you feel?

A. I couldn't say baby girl. We had a baby on the way. We didn't know at the time.
Q. How did you feel about that?
A. Really excited at the time. Just super anxious because it was a new turning point in my life.
Q. Did you and Carissa talk -- how was she about the whole --
A. Same boat as me.
Q. You were pretty young?
A. Yeah. I've always got comments that I was like -- I was ahead of, like, my age. I don't know why people would like to tell me that, but I've gotten it my entire life. So for me, it wasn't as much, but for her, maybe.
Q. That you look maybe a little more -- I don't want to say mature, but a little bit older than you are.
A. I don't know about now. I had to shave my face. I'm not used to this look at all, by the way.
Q. Let me ask you about after you and Carissa talked about becoming pregnant or after she became pregnant, did you make any decisions with her?
A. We made plenty of decisions together. I know when we had found out that we were going to have the baby, instead of living in the apartment, we knew that wasn't going to be something for us for the rest of our lives, so we ended up looking into getting a mobile home.
Q. Now, we have some other pictures that we can show to have

a little bit of insight into your life before Kendall came along, so if you could pull up Exhibit 24, and can you explain to us what this picture is of?

A. That was us at a Pirate game, and what was funny about that day is like we showed up super early. I don't know why. They put big red arrows and they hide them in the seats and if you find a big red arrow, you get to take a picture with the big parrot that they have. I don't know if that's the right term for the mascot. It was right under our seat and we got to take a picture with the big parrot.

Q. And this was after high school?

A. Yes.

Q. You can take that picture down.

The next one I'll show you is Exhibit 25. Can you tell us about that picture?

A. Yes. That picture, there was -- that bridge that we were on a bridge at the moment right now and it was just built so it was brand new, and it's the first time that we had driven on the bridge, so while we were at a red light, I thought it would be cool if we captured that memory together.

Q. So you weren't moving at the time the picture was taken?

A. No. The car was not moving.

Q. The next one is Exhibit 26, and can you tell us what this picture is of?

A. From the look of my eyes, I know I was just getting off of

work maybe, but we were at a doctor's appointment to check up on the baby to see how things are going.

Q. Did you go to any of the prenatal visits?

A. I went to a couple, I believe, but I didn't attend a lot of them just because of my work schedule.

Q. And do you remember what was happening at this visit?

A. I can't quite remember exactly what was going on at this visit.

Q. Do you ever remember whether or not you, before delivery, found out whether it was going to be a boy or girl?

A. Yeah. At one point we got to find out. I don't remember how because there was -- our shifts were so crazy. We worked 16-hour shifts, 12-hour shifts, come home, go to sleep, wake up, do it again. There was a lot of information that was passed my way, but I know, at one point, I definitely found out what we were having.

Q. So Carissa would keep you in the --

A. Yes, the best she could.

Q. The next exhibit we'll pull up is Exhibit 27. This is a picture. She is obviously pregnant at that point?

A. Yeah.

Q. Can you tell us what was happening in this picture?

A. I'm not sure what holiday we were celebrating. Something before October. This may have been Labor Day, maybe, but yeah, we were just at family's house, having a pool party and

we were all hanging out together.
Q. Do you remember whether or not Carissa told you while she was pregnant whether there were any concerns about the pregnancy?
A. There was never any concern that I was aware of at all.
Q. Sometimes, there are prenatal classes offered where, you know, mothers and fathers they'll go to learn about delivery and things like that.
Were you and Carissa -- did you ever go to any of those?
A. No, we never did.
Q. Do you remember were you ever offered them and just said I don't want to go, or did you ever learn about them?
A. I would imagine it was offered to us, but no, we never had any of those classes.
Q. Let me ask you a little bit about your experience, I guess, leading up to this. Had you ever been present in a labor and delivery room when a baby was being born?
A. In the process of a baby being born, no, but I was in the room when my niece was born, like well after she was born. I got to be there for that.
Q. So you were able to go into the -- to see your niece after she was born?
A. Yes.
Q. So the actual birthing process, you had never experienced it?

A. No.
Q. Were you scared?
A. Myself to be in there? Was I scared? I was definitely nervous, you know, to say the least, yeah.
Q. The due date was coming up in October, because the due date was October 12?
A. Yeah.
Q. Tell us about preparations that you and Carissa were making for the birth.
A. Everything under the sun. We had to get the crib, you know, get the supplies, diapers, you know, prepare -- what do they call those for the female? Diaper party? No. Is that what it's called? I'm not quite sure, but you know planning all those things, and also we were in the process of getting ready to move out of the apartment into the mobile home that we had purchased.
Q. How about a baby shower?
A. There we go. I don't know what I was thinking.
Q. I'm sure they give out diapers too.
A. The majority of everything that comes is diapers, so it's pretty much a big diaper party.
Q. Okay. So Sunday, October 12, 2014. October 12, 2014 was a Sunday?
A. Yeah.
Q. Do you remember that day?

A. It's one of the hardest days for me to forget actually, but yes, I remember. We had gotten up at around 5:30 on that day, 5:30 in the morning. My shift started at 7:00, so we were going through the basic routine, coffee, breakfast and all this. She drops me off at work. I get into my shift.

Maybe at this point, it's probably 8:30 or 9:00. I get a text message from her and she is just stating that her water broke and she called some -- called the doctor to get confirmation, and she got the go ahead to go up to the hospital, and then she had come to pick me up from work, and we went straight up there.

Q. Now, do you remember about what time you guys got to the hospital?

A. Probably like before 11:00, after 10:00. It was just around 10:00.

Q. Did you get -- did you both -- I don't want to say get admitted, but did you go into the hospital and they checked you in and stuff like that?

A. Yes. Immediately. Yes. They were very prompt. They got us where we had to be and got us in the room. Got her all hooked up and we were ready to go.

Q. Tell us a little bit about that, getting into the room, getting hooked up. What did you see? What happened?

A. Oh, my, just a whole bunch of, like, this is really going to happen. Just so anxious for this to really be here.

Q. Do you remember any of the nurses who were caring for you when you came into the hospital?
A. Not up until Monday. I recalled no nurses up until this week.
Q. You mean until Monday morning?
A. No, like -- what was your question?
Q. Do you remember any of the nurses?
A. Now I do.
Q. From seeing them here on the stand?
A. From seeing them here, yes.
Q. Now, besides seeing them here on the stand, I don't want to say you remember their faces or remember the conversations, but do you remember what happened during the October 12, while you guys were admitted, into the 13th?

Do you remember what was happening at the hospital?
A. Yeah. A few things were going on. You know, clearly they're doing their job. They're checking on her. They are informing me on certain things. One nurse was pretty -- she was engaged with us, to say the least. Like she wanted to communicate and to reassure us that everything was going to be fine, everything is okay.

She knew what her job was to do, but she would -- like a little test for me, she would have me, like, check in with her every 15 minutes, like, what she had to do, and this was all in the process of, like, the labor. She would tell me, like,

hey, every 15 minutes come remind me of this. Obviously, she knows what she has to do, but it was kind of for me to be on my game.

And I can vividly remember one nurse, like, she would take notes on her pants leg, but I guess in the hospital world, that's just kind of a normal thing that they do, and there was one nurse who wasn't sure how to use one of these strips. I'm not sure what the strip was for, but she had to literally pause for a minute and tell us I have to read the directions. Give me a minute before I use this.

There was no red flags in my head because we are here, we are here in your care, and I'm going to let that be what it is, and I would much rather you read the directions.

Q. If you could pull up Exhibit 28. I know the picture is tilted, but is this what you kids term a selfie?

A. Yes.

Q. Carissa is taking it while she is in the bed and this is during her labor?

A. Yes.

MR. PRICE: Your Honor, if you don't mind, at this point, we're going to get into a little bit more of the delivery, and this might be a time to break.

THE COURT: That works for the court, and as we know, one of our jurors needs to catch the bus, so we're going to pause here and we'll hear more from Mr. Fritzius tomorrow. I

also understand we have some additional witnesses including an expert tomorrow; is that correct?

MR. PRICE: Yes.

THE COURT: Ladies and gentlemen of the jury, as per usual, you'll put your binders and notebooks on your chairs to be picked up by Mr. Galovich.

Once again, let me remind you of the recess instruction. No talking about the case, no researching about the case, no communicating about the case. Again, if anybody should approach you about this case coming in tomorrow, for example, at any time, let us know that. Continue to keep your minds open. You still haven't heard all of the evidence and you haven't heard my final instructions.

With that, safe travels home. It's a nice night outside. I hope you get some time to enjoy it. Everybody should stand for our jurors.

(Jury excused.)

THE COURT: Mr. Fritzius, you may step down, please. Besides Mr. Fritzius, Mr. Price, what else do you anticipate tomorrow. Still Dr. Karotkin; is that correct?

MR. PRICE: Dr. Karotkin, Dr. Min, Kylee Fritzius, and then Carissa.

THE COURT: Now, vis-a-vis Dr. Karotkin, is he going to be here first thing in the morning? Should we interrupt Mr. Fritzius and then have Dr. Karotkin? Is that what you are

going to do?

MR. PRICE: If you wouldn't mind, yes.

THE COURT: How about Dr. Min? Does he have to be anywhere else?

MS. KOCZAN: Your Honor, I was going to ask Mr. Price what time he wanted him here. He's waiting to hear from me as to the exact time.

MR. PRICE: I don't think I'm going to be really, really long with Dr. Karotkin. I would ask that he be here, I don't know how much cross-examination, but 10:00, 10:15, so right after the break, I could put him on.

THE COURT: So do you think he could be downtown around 10:30 or so?

MS. KOCZAN: I will tell him that's when I would like him.

THE COURT: All right. And as far as these other folks, there's no problems with their appearing, right?

MR. PRICE: Correct.

THE COURT: Okay. Well, then everybody can have a good night. We'll see you here tomorrow, unless there's something else, Mr. Price?

MR. PRICE: One issue, Your Honor. It's with regard to, and I spoke with Mr. Colville about this, but I wanted to put it on the record. On Tuesday, their expert Dr. Wiesenfeld is to be testifying. Dr. Wiesenfeld's report was filed.

However, the remainder of the 26 -- Rule 26 information concerning his list of cases and compensation has not yet been filed.

THE COURT: He needs to get busy, so where is the list of cases and compensation?

MR. COLVILLE: It was an oversight, Your Honor. I reached out to the doctor this afternoon when I heard from Mr. Price. Hopefully, it's being processed to me and sent to me and I can file it.

THE COURT: It's a Rule 26 violation.

MR. PRICE: The only other thing I would ask is that it be filed because it was filed -- all of Ms. Koczan and our experts' reports are filed and I think that they should all be filed of record.

MR. COLVILLE: I'm not sure what the purpose of filing it is.

MR. PRICE: I guess the purpose is since my experts have disclosed all of their compensation and their lists, he should too.

MR. COLVILLE: I don't think that's common in federal court to file the report.

THE COURT: That you file them and make some of them proffers. Ms. Koczan, what did you do? Did you file yours? I think yours were filed.

MR. COLVILLE: I think that's after we objected, Your

Honor, for having it filed to begin with. This was a nonjury case as to the United States, and the expert reports were filed with the court, the finder-of-fact.

THE COURT: Yes, you made that objection. I have to read them anyway, and I read them all.

MR. COLVILLE: I understand, Your Honor.

THE COURT: So you did file your reports of record, so is this Dr. Wiesenfeld used widely?

MR. COLVILLE: By us, no.

THE COURT: I mean, in general.

MR. COLVILLE: No, I don't think so. I don't think there's going to be much at all.

THE COURT: I guess somebody could Google him, so let's get Dr. Wiesenfeld's information first thing and I'll take a look at it and determine if we need to have it filed or not. Okay, but we need it.

MR. COLVILLE: As I said, Your Honor, as soon as I heard, I texted him this morning.

THE COURT: This case has been around for a while. This trial has been listed for a while. It was relisted thanks to a criminal defendant, and hence, it should have been produced a while ago. Now, any other issues?

MR. PRICE: No, Your Honor.

MS. KOCZAN: The only other issue, and we brought this up before, is with regard to next week. Mr. Colville has

Dr. Wiesenfeld on Tuesday. All of my experts were previously scheduled for Wednesday. I intend to have all three of them there on Wednesday, but I can't get them there on Tuesday because of the previous -- the court's previous scheduling was that we were not going to have court on Friday and that's why we did it that way.

THE COURT: There's court and there's court. We still have a Rule 50 motion I have to have argument on, correct. I still have to make ruling on that. We still have to have a charge conference and there may be some other legal issues, so be that as it may. If they are not here until then, they are not here until then.

MS. KOCZAN: Your Honor, what would you like me to do? Would you like me to have my other witnesses on Friday, or would you prefer to have them on Tuesday because I have two more nurses that have to go on and Dr. Jones depending on what you do with the Rule 50 motion, but she can testify regardless.

THE COURT: Okay. First off, Mr. Price, you are going to put on Dr. Karotkin, Dr. Min, Kylee, Matt has to go back on and finish up, and Carissa, right?

MR. PRICE: Correct, Your Honor.

THE COURT: Are you going to have Carissa testify both liability and damages, because at one point you said you were going to split that?

MR. PRICE: I'll have her testify to the whole thing.

THE COURT: That sounds to me like, at a minimum, we're going to fill all day tomorrow right there, because the court, again, has a meeting at lunchtime. This time, it's about pro ses, and that's from noon until 1:15, so we're going to take that same kind of a lunch break.

And then on Friday, is it your intent to call anybody else, Mr. Price, or are you going to be resting?

MR. PRICE: Your Honor, I intend to rest, yes. I'm resting.

THE COURT: Are you? Okay, because Ms. Koczan is indicating that she is going to have at least two nurses that might need to testify, right?

MS. KOCZAN: Your Honor, currently, I asked them for next week because when I originally scheduled, we did not think we would be here on Friday, so that's why I have them lined up for next week, and then I asked initially my experts, two of them are going to be here on Wednesday, one on Thursday.

I got them all moved to Wednesday hoping we can get them all in and expedite things, so my question to you is do you want me to see if I can get those nurses Friday or is it okay to leave them on Tuesday.

THE COURT: I think we'll leave them on Tuesday because if we finish everybody tomorrow on the plaintiffs'

side and perhaps have somebody that needs to finish up, then the plaintiff is going to rest, and I'm anticipating arguments on the Rule 50, and I need to make a ruling, and then I'm anticipating that given these "witness problems," we'll just move right into a charge conference and so we get that all done, so that's one way we could approach things.

Now, if these ladies want to come in and be done before Labor Day, I would be happy to accommodate them.

MS. KOCZAN: I can certainly call them. I don't know what their schedules are because I had originally told them next week, but I can make a phone call.

THE COURT: Sure.

MR. PRICE: Your Honor, if I may. I have squeezed witnesses into every minute of this trial at least three days. I am --

THE COURT: Which I and the jury very much appreciate.

MR. PRICE: However, I know and I have tried cases with defense before, and the case will drag and the case will drag. We will end early on Monday, we will have to -- and it hurts me the longer --

THE COURT: Monday we won't be here. I hope we'll all be at a cookout somewhere, not all together but individual cookouts. It's Labor Day.

MR. PRICE: These nurses, who do you have?

Nurse Ash, who I'm going to ask for an offer of proof because the only relevant testimony she can have is that she saw the meconium fluid at the time of delivery, then she went off shift at 7:00.

Nurse Hackney was only there for five minutes, and Nurse Gantz, she was there at the time of delivery, so she might have something relevant to say, but she didn't have much in her deposition, so I can't see them filling up, and you've told us last week that we were going to be having trial on Friday.

THE COURT: I did, because it was represented to me by our law clerk that you were going to have all these witnesses and all these experts and we need to get this case done so that's what I did.

MR. PRICE: I'm doing it. I'm getting it done, but now from what I'm hearing is, well, and that's -- I hate to say it because this always happens to me.

THE COURT: We'll see one thing after another. So first, Ms. Koczan, why don't you see if Nurses Ash, Hackney and Gantz are available on Friday and see what their preference is. Are they still working for the hospital or are they someplace else?

MS. KOCZAN: First of all, I don't intend to call Nurse Gantz because she doesn't remember anything. That is not my intention to do that. She doesn't remember. My

intention was to call Nurse Ash.

THE COURT: You want to give us a proffer?

MS. KOCZAN: It will be with regard to meconium and what she did and what she saw. And --

THE COURT: Is she still employed by the hospital?

MS. KOCZAN: She is. And then Nurse Hackney is the nurse who accepted Kendall into the nursery. She is no longer employed by the hospital. She is employed elsewhere now, so that's why, as I said, the original plan --

THE COURT: She might be a little bit difficult to get in, but Ash, if she is still working for the hospital, should be easier to get in.

MS. KOCZAN: That would be fine. I don't anticipate a problem with her because the hospital will accommodate that.

Nurse Hackney, obviously you have to work around her schedule, and I did tell her based upon earlier representations that it would be next week. I certainly can call her. I don't know for certain whether she can be there, and of course, I have Dr. Jones who I could have testify either Friday or Tuesday, and then, per previous representations, I have my experts for Wednesday.

THE COURT: Understood. It's not your intent to call Dr. Jones in your case, Mr. Price?

MR. PRICE: No.

THE COURT: Anything else then that we need to

discuss? Dr. Wiesenfeld needs to get his list of cases and how much he's being paid up to you, Mr. Colville, ASAP. I want to see a hard copy, and I'll make a determination if it needs to be filed or not.

We do now have a proffer for Nurse Ash. You are going to do your best to see if she might be available if we need her on Friday and I understand Dr. Wiesenfeld will be here first thing Tuesday, and the rest of the experts on Wednesday, and the other times, as I said, we'll be filling in if we need to vis-a-vis the Rule 50 motion and the charge conference.

Of course, Mr. Colville and Mr. O'Connor don't have much to offer on the points for charge unless they want to weigh in on comparative negligence. Maybe they want to do that. Anything else?

Have a good evening, everybody.

(At 4:55 p.m., the proceedings were adjourned.)

C E R T I F I C A T E

I, BARBARA METZ LEO, RMR, CRR, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled case.

\s\ Barbara Metz Leo 09/25/2019
BARBARA METZ LEO, RMR, CRR Date of Certification
Official Court Reporter

I N D E X

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